DOCUMENT RESUME

ED 386 645 CG 026 464

TITLE	Teenage Pregnancy. Hearings before a Subcommittee of the Committee on Appropriations. United States Senate, One Hundred Third Congress, Second Session. Special Hearings.
INSTITUTION	Congress of the U.S., Washington, D.C. Senate Committee on Appropriations.
REPORT NO	ISBN-0-16-046176-6; Senate-Hrg-103-818
PUB DATE	25 May 94
NOTE	225p.
AVAILABLE FROM	U.S. Government Printing Office, Superintendent of Documents, Congressional Sales Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC09 Plus Postage.
DESCRIPTORS	Adolescents; Child Welfare; *Early Parenthood; Family Planning; Hearings; Pregnancy; *Pregnant Students; *Public Health Legislation; Secondary Education; Sex Education; Sexuality; Youth Problems
IDENTIFIERS	Congress 103rd

ABSTRACT

The Senate Subcommittee met in order to examine the alarming increase of out-of-wedlock teenage pregnancies in the United States. Information provided at the hearings included: the scope of the issue; input from experts on what is causing the increases being recorded; different approaches to reducing teen pregnancy; and, teen parent perspectives. Statements were given by organizations such as: Women's Health Services, Teen Services Program, Athletes for Abstinence, Family Court Division of the City of Philadelphia, Sex Respect, Inc., and the Philadelphia Board of Education. Dr. Jocelyn Elders, Surgeon General, also gave a statement. Topics discussed include: pressure to become sexually active, role of mass media, young men's responsibility, the role of parents, comprehensive health education, abstinence, welfare, and the use, cost, and availability of Norplant were addressed. Extensive charts, graphs, program descriptions, and testimony are included. (JBJ)

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TEENAGE PREGNANCY

ED 386 645

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

SPECIAL HEARINGS

Printed for the use of the Committee on Appropriations

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81–864 cc WASHINGTON : 1994

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Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
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TEENAGE PREGNANCY

WEDNESDAY, MAY 25, 1994

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:38 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Specter, and Stevens.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

STATEMENT OF HON. M. JOYCELYN ELDERS, M.D., SURGEON GENERAL

OPENING REMARKS OF SENATOR HARKIN

Senator HARKIN. The Subcommittee on Labor, Health and Human Services, and Education will come to order.

This morning at the request of our distinguished ranking member, Senator Specter, the subcommittee will be examining a critical issue, the alarming increase in out-of-wedlock teenage pregnancies.

This year over 1 million American teenagers, nearly 11 percent of 15 to 19 year olds, will become pregnant. This rise in out-of-wedlock teen pregnancy is a national problem. It is not just an inner city or low income issue. It impacts all areas of the country, urban and rural, and all socioeconomic groups. Over 1 million American teens will have children this year.

I was very disturbed by a report out just several weeks ago which found that while my State of Iowa is near the top nationally on the overall well-being of children, teen pregnancy there is also surging. The rate of births to teen moms who are not married grew at twice the national rate, from 5.1 percent to 7.8 percent, an increase of 54 percent. Even more disturbing, the age of teenagers having babies in Iowa and across the Nation is dropping. It is shocking that we are seeing more and more 12 and 13 year olds becoming unwed parents.

That is why this hearing is so important and why I want to commend Senator Specter for urging us to hold this hearing. We will look at the scope of the issue and get input from experts on what is causing the increases being recorded. We will also hear about a number of different approaches to reducing teen pregnancy, and most importantly, we will hear directly from teen parents on their

perspective of the problem and their thoughts about what approaches are most effective in reducing the rate of teen pregnancy.

I am pleased that we have as our lead-off witness, the Surgeon General of the United States, Dr. Joycelyn Elders. Dr. Elders has worked tirelessly to address the problem of teenage pregnancy both in her previous position as head of the Arkansas Department of Health and now as Surgeon General of the United States. I am pleased that we have three Iowans who will share their views with us.

At this point I will stop and recognize our ranking member, Senator Specter, for any opening comments.

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Thank you, Mr. Chairman. At the outset I thank you for your leadership on this subcommittee generally and for your leadership on this important subject and for scheduling these hearings.

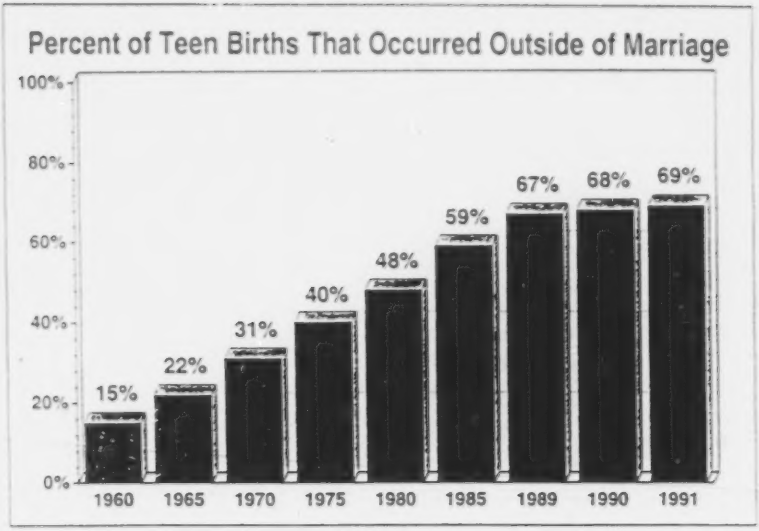
The problem of unwanted teen pregnancies may be the core problem in America today. I do not say a problem or one of the major problems, but may be the problem.

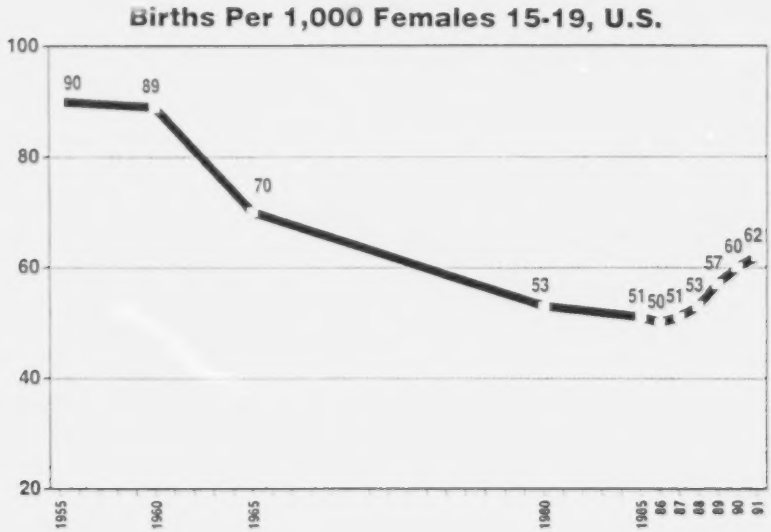
The leader on this subject and perhaps the leader nationally has been our colleague, Senator Pat Moynihan, who has studied this issue and who has the most elaborate set of charts that I know of. Well, perhaps not quite as elaborate as those prepared by our staff here today, but Senator Moynihan has drawn public attention, national, international attention, to the fact that the number of unwanted teenage pregnancies has practically gone off the charts and it is a problem of enormous magnitude because these children who give birth to children, who in 50 percent of the cases were given birth to by children themselves so that the role models are continued, create a situation where at the outset there is no family structure, which is a tremendous disadvantage, perhaps the greatest disadvantage identifiable.

Many of these children are born as low birth weight children. I was amazed a decade ago when I saw my first 1-pound baby, a human being about as big as the size of my hand, which is a human tragedy carrying problems from the day of birth throughout the entire life and a financial burden for the country, $150,000 on an average before leaving the hospital and enormous expense during the lifetime.

The issue of teenage pregnancy is very heavily on the welfare issue, very heavily on the inability for having education, for job training, for crime control. It is just an enormous problem.

Those charts—and I thank the staff for that—show on chart 1 that between 1986 and 1991 the rate of births to teens age 15 to 19 rose 24 percent. Chart 2 shows the comparative disadvantage of the United States, with that long, blue line at 62 per 1,000 teenagers compared with 4 for Japan and 6 for the Netherlands and 9 for Denmark, and many lower numbers. Charts 3 and 4 demonstrate the dramatic increase in births to unmarried females since 1980 with unmarried birth rates rising 21 percent over that time period.





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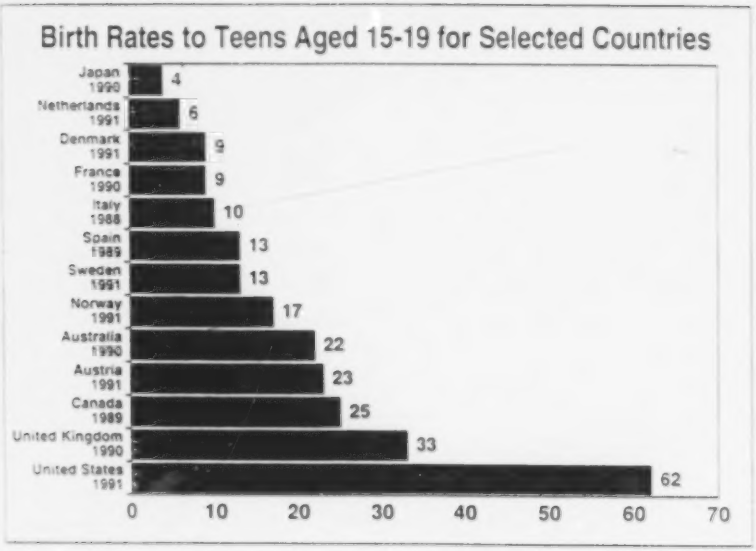

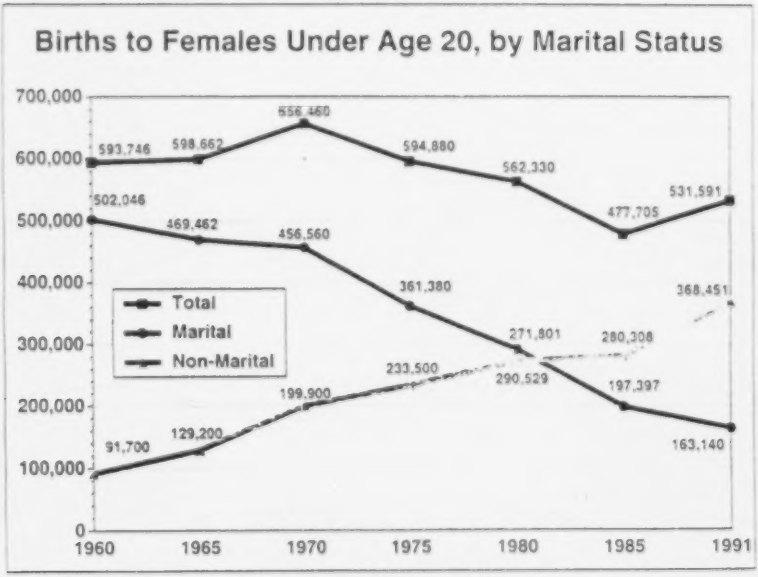

PREPARED STATEMENT

This problem did not descend on us overnight and it is obvious that we will not solve it overnight, but there are many things which can be done. We have to increase our efforts. We talk about

extension, just say no, and we shall hear today from witnesses who are teens who bring on positive peer pressure. Just say no, however, has to be understood not to be sufficient, and we have to say some other things as well.

Having said that, I have probably said too much, so we ought to turn to the experts who can provide some guidance on this subject.

Mr. Chairman, I would just ask unanimous consent that my full statement appear in the record as well.

Senator HARKIN. Without objection. Thank you very much, Senator Specter.

[The statement follows:]

STATEMENT OF SENATOR ARLEN SPECTER

This morning, the Subcommittee on Labor, Health and Human Services and Education has convened a special hearing to discuss the causes and consequences of teenage pregnancy, and to explore the role the Federal government can play in decreasing the number of unintended pregnancies.

When one talks of social ills in America today, the problem of increasing numbers in births to adolescents is always at the top of the list. As is shown on chart 1—between 1986 and 1991, the rate of births to teens aged 15–19 rose 11.9 percent, from 50.2 percent to 62.1 births per 1,000 females. This increase occurred among both younger and older teens and holds for all ethnic groups and all regions of the country.

It is also worth noting that the teenage pregnancy rate in the United States tops that of all other developed countries, despite the fact that those countries have similar rates of sexual activity. The U.S. teen birth rate is more than double the rate of teens aged 15–19 in Canada and Australia. France and Japan report the lowest rates of teen births with 9 and 4 births per 1,000 respectively, in the 15–19 age bracket (chart 2). These statistics suggest that European teens are much more likely to use contraception than their American counterparts, putting American teens at comparatively higher risk for sexually transmitted diseases.

Charts 3 and 4 demonstrate the dramatic increase in births to unmarried females since 1980, with unmarried birth rates rising 21 percent over that time period.

We must find programs to address the teen pregnancy problem as is indicated by the rising costs associated with teen births. In 1990, an estimated 51 percent of Aid to Families with Dependent Children payments went to recipients who were 19 or younger when they first became mothers. Based on estimates of AFDC, Medicaid, and Food Stamps, support to families begun by a teen birth cost the U.S. over $25 billion in 1990, up $3.5 billion from 1989. It is estimated that if every teen birth had been delayed until the mother was in her 20's, the U.S. would have saved 40 percent of these expenditures, or $10.2 billion.

I look forward to hearing your testimony and discussing your ideas on how the problem can best be addressed.

OPENING STATEMENT OF SENATOR TED STEVENS

Senator HARKIN. I recognize Senator Stevens.

Senator STEVENS. Mr. Chairman, Senator Specter, I will not take very long. I have another appropriations hearing. As you know, we have several at the same time.

I stopped by to tell you that I think one of the great shocks I have had in my life here in the Senate was when two school nurses came to visit me from Alaska and asked me to consider introducing legislation to provide day care centers for young women in schools. I said, well, under the budget situation we have now, I just do not see that we can do that. I am sure we have a great interest in high school young women. They are still girls to me and that is the word I used. They quickly pointed out to me that they were talking about girls in grade school, just almost preteenage mothers in our State. We have an increasing problem.

That is why I have come by. I do not think this is a problem of just the large urban centers. This is as much a problem of rural America as anywhere else in the country.

We have one rural area just outside of Anchorage which has an exemplary school-based program for at-risk students, and it is called teen parents and pregnant teens. Peter Burchell there has developed a program that does work, and I would like to leave with the committee some of the documents that he has sent to me. It is called the Mat-Su—that is a borough in our State, like a county would be in yours—alternative school from Wasilla, AK.

This is a program that helps not only the parents of pregnant teenagers, but the pregnant teens themselves and has tied together a concept of a commitment to graduate from school, to finish school, as well as committing the community to help the teenage mother after she delivers her child and to provide education and employment to keep that family going and bringing the teenage mother back together with her parents. I think it is one of the most exemplary programs I have seen. I would urge the committee to study that.

But basically I want to agree with what both of you said. I join Senator Specter in saying I think this is the most important program that we have to pursue. You tie together just the problem of the pregnancies you see in this chart in our State and then add to that the fetal alcohol syndrome and fetal alcohol effect consequences of some of these births that occur as a result of teen pregnancy, and you will see the compounding problem for America if we do not solve this. Most of those births that take place in my State among teens are also associated with abuse of alcohol.

Thank you, Mr. Chairman. I appreciate this hearing very much.

Senator HARKIN. Thank you, Senator Stevens. We will insert into the record at this point the above mentioned documents.

[The information follows:]

MAT-SU ALTERNATIVE SCHOOL, MATANUSKA SUSITNA BOROUGH SCHOOL DISTRICT, WASILLA, AK

Mat-Su Alternative School (MSAS) opened its doors February 8, 1988. The program had 5 students, and was funded by a JTPA grant. Within the Matanuska Susitna Borough School District there are over 10,000 students, and at the time, the need for dropout prevention and dropout recruiting was evident. The school grew by 2,300% in just five years! (yes, two thousand three hundred percent!) MSAS is structured to meet the social, psychological, health, and educational needs of each student. The program is based on the problem solving model; define the problem, look at alternative solutions, pilot programs, evaluate results, and re-adjust course of action for each student.

MSAS utilizes four basic methods for students to earn credits to graduate with a high school diploma. The first is in-house classes: History, Math, Life Skills, Parenting, World of Work, Speech, Journalism, Applied Communications, Art, and Health. The second is integrated learning systems (CCC & WASATCH) which are self-paced computer programs. The third method of instruction is individualized correspondence courses. Last, students can earn credit through cooperative work experience. Credits to graduate from MSAS exceeds the district requirements for graduation. MSAS operates twelve months a year. It opens at 7:00 a.m. and closes at 5:30 p.m. Students may enter or exit the program anytime during the year. Students must attend school a minimum of 3 hours a day, secure a job and work 15-50 hours a week, and cooperate with staff and employers.

To be eligible for enrollment at MSAS, a student must be at least 16 years old, dropped out of school previous semester, and behind in credits to graduate. In 1988 there were 5 students enrolled. MSAS has served 160 student in 1993, with the current enrollment at 115. There is generally a waiting list of about 20 students. Sixty percent of the students currently enrolled are carryovers from previous years. Since beginning the program 75 students have graduated with another 45 anticipated in May, 1993. Although students can complete the program anytime, MSAS holds a graduation ceremony at the traditional school year end for all who graduated throughout the year.

MSAS networks with social service, advisory boards, and community agencies to provide support for the students. The school hosts five support groups each week. Local agencies provide the facilitators: AA, Victims of Sexual Violence, Anger Management, and Kids Are People. The school nurse and teen parent case manager refers students to local health agencies. MSAS works with JTPA, Job Service, and local business for job placement as volunteers and paid positions. In addition to the work requirement, all students are required to complete JTPA pre-employment or World of Work course. MSAS works closely with welfare and the JOBS program for teen parent job placement.

In the past five years there have been 80 pregnant or parenting teens in the program, currently, there are 43. Half of the graduates at MSAS have been teen parents. MSAS has a program specifically designed for pregnant or parenting teens that includes: a close working relationship with JOBS an Job Service, a Life Skills Parenting teacher, an on-site licensed child care center for 20 children, a case manager, a work experience coordinator, and a school nurse. The child care on-site provides opportunities for co-op work students to earn credit in childcare.

MSAS works closely with Welfare, Housing Authority, Alaska Food Bank, and local churches to secure food and shelter for the students. Forty to fifty percent of the students do not live at home. There is also a food bank and clothing bank within the school and administered by the school nurse. Most students have to supply their own transportation to school and work. Since 1992 there has been a mini-school bus to help with transportation.

MSAS operates under Matanuska Susitna Borough School District budget and guidelines. In addition, student body composition makes MSAS eligible for several grants: 100% are dropouts, 30-40% are pregnant or parenting teens, 85% are low income, 35-40% do not live at home, 10-15% qualify for Special Education. The school district budget for MSAS in 1993 was $563,000. A Drugs Free Schools grant for 1993 was $20,000. Teen Parent state and federal grants were approximately $225,000. Funding provides for one principal/teacher, four full-time teachers, one full-time Special Ed. teacher, one full-time Special Ed. aide, one case manager, one school nurse, one half-time Parenting teacher, one part-time job coordinator, two full-time child care operators, two full-time secretaries, one half-time secretary, and one quarter-time secretary.

MSAS began in part of a portable classroom in 1988, moved into two donated store-front shops in 1989, moved into a vacant high school library room in 1991, then moved into another store-front building in 1992. The current facility is approximately 40' x 60' with a general study and

computer area, a nurse's office, and two divided classrooms. The child care is in a separate room approximately 20' x 20'. Current needs are: a PERMANENT larger building with office space, laundry facilities, showers, kitchen, and gym space which will be available in 1994 with a $2,100,000 grant.

The Mat-Su Alternative School began in the Spring of 1988 with a class of five students. One student was a teen mother. The school continued to attract more students and presently has one hundred fifteen students enrolled. The original location of the school was in a local shopping center with space donated by the TRF Management Company. That site was quickly outgrown and the school found a new home in the Colony High School in the fall of 1990. The Alternative School's daycare program has undergone a similar evolution. Supported by funds provided by the Alaska Department of Education daycare assistance for students is now available in the school. The personal service and attention to individual needs of students within the scheduling format, vocational and academic programs attracts not only pregnant and teen parents but others with special needs.

The problems and challenges presented by teenagers bearing children are real, and yet with support can be met. The young teen, and for the most part single mothers of America, and in particular, the Mat-Su Valley, are representative of the most uneducated and economically disadvantaged segment of our society. Doors to conventional high school education close, as do the doors to vocational training and job placement. When most in need the teen parents become isolated and shut out. In this cycle of despair the victims are the children of these teen parents, the young parents, and society.

The practitioners who work with teen parents in the Valley are in agreement about the need for daycare for teen parents and pregnant teens. The Advisory Committee to the school (Teen Parent Advisory) strongly support a daycare facility located at the Mat-Su Alternative School. The goal is to provide quality daycare for infants while providing academic and vocational training for pregnant and teen parents. The project served 45 eligible participants during the 1993-1994 school year.

The project has the support of local community groups, social service agencies, health care providers and local teen parents or pregnant teenagers; many who serve on our advisory committees. Members of the Teen Parenting class have been instrumental in defining problems to address in this area. In addition, they provide support for each other by co-op babysitting, passing down used clothing, sharing advice, and generally being there for each other.

The project will continue to coordinate its needs with the JOBS Program and AFDC. It will also continue to work with the Valley Women's Resource Center, local churches, other high schools in the District, city and borough offices and the Chamber of Commerce to secure employment, donations, mentors and advice to provide expanded opportunities for all students in our program. All of this represents a beginning in helping young "at-risk" parents in a time of need.

The immediate goal of this Alternative School project is to keep teens in school and help them graduate by expanding the daycare program to provide on-site care, to improve services for both infants and teen mothers, and to increase the vocational and academic opportunities at the school to meet the needs of students.

The Alternative School has been successful in helping teen parents graduate from high school, successfully complete GED's, enter post-high school education or enter the job market. For five years the school has managed to build and improve its instructional program. At the same time the moral and financial commitment of the school district and community continues to grow. Initially, the school contracted daycare services with private daycare centers. Later, new components were added to the program. The major new additions are: a public health nurse to handle referrals and provide medical advice and coordinate services; a parenting and life skills class staffed by a certified H. Ec. teacher; vocational daycare component; a case manager; a part-time secretary; and a small bus and driver to transport students and their babies.

The long term plan for MSAS is to expand from grades 9-12 to an infant through 12th grade by 1996. There are many students who will benefit from an individualized prescriptive format. We have school commitment and community support for that expansion. We now have a school district Vision and Mission format to work towards. We, at the Mat-Su Alternative School, have profited from this new sense of direction. Our budget and administrative support are indicative of that change. There is a **2000% growth** in the number of students the school can now serve. The staff has increased from 1.5 to 11.1. The year 1998 is significant in that we will then have K-12 in the program. The school will have expanded from a dropout only program to a true alternative school.

The Alternative School has gained invaluable knowledge and agency cooperation over the past 5 years. Teen parents and pregnant teens are an exception to our admissions policy. All other students must be 16 years of age, a dropout, and behind their class on graduation. It will be our continued goal to provide an environment for all special needs students and hopefully in our own facility within three years.

Academic skills of each applicant is assessed by testing to identify remedial instruction which will be required to function effectively as an employee (reading, mathematics, writing, and social skills).

Applicants are interviewed and evaluated by a Teacher/Advisor to assess the type of instruction appropriate to develop Life Skills, civic responsibility, readiness for occupational responsibility, consumer knowledge, ability to access community resources. Schedules will include life skills, parenting class, world of work, and other academic classes to complete their high school diploma or GED. The goal is to help at risk students develop the skills to compete in the post high school world. Particular emphasis is placed on those preparations needed to secure employment or pursue post-high school alternatives.

Each student receives a vocational evaluation to identify career areas where successful placement is most probable. The tests may include, but are not limited to, TAP, ASVAB, VALPAR, JTPA, Pre/Post tests, AKCIS, and Career Planner. We will utilize Job Service, HRC, and district assessments for part of the testing.

Screening occurs throughout the year. We are a 12 month school that never closes the door on it's students. When students complete their GED or graduation requirements, they exit the program. It is the program goal to serve 115-130 students during the year.

Each participant must demonstrate good attendance and work habits by adhering to established attendance policy. There are special allowances for teen parents due to illness of children.

Each participant must demonstrate a desire and ability to complete his or her education by developing and successfully completing a plan towards that end.

The students must demonstrate earned academic credits and skills acquired. Those are to include correspondence study, individual learning programs, classes on the Integrated Learning System utilizing software from CCC, WASATCH, and CSR and participation in classes. The school is open from 7:00 a.m. to 5:30 p.m. to serve the needs of all students.

The students must demonstrate positive attitudes about self, others that he/she works with, and about work and the work environment, as documented by their bi-weekly worksite evaluations. Worksite visitations by staff members will provide further data.

Instruction will be based on individual needs and ability. Students are scheduled for a minimum for 15 hours a week at the school.

a. Instruction is prescribed for each participant.

b. Instruction is paced to the ability of the student.

c. Upon mastery of prescribed skills, the participant is advanced to the next higher skill level.

d. Job seeking/procurement skills is an integral part of initial instruction (resume preparation, application forms, job search techniques, interview techniques, and appropriate attire/grooming skills).

The community is canvassed to identify job sites appropriate to the verified skills and interests of students.

a. Potential jobsites are discussed with students.

b. Students are assisted with applications and interview arrangements.

c. Job Service's resources are coordinated with the Mat-Su Alternative School. They have a new job counselor to help school-age youth.

d. Eligible students are referred to Human Resource Company for JTPA training and placement.

e. Paid employment procurement is not guaranteed.

Following the start of employment the work experience coordinators check the jobsite on a regular basis.

a. Coordination on a daily/weekly basis is continued where deemed necessary by the work coordinator.

b. After a month of successful employment, coordinator visits may be reduced to once or twice a month.

Practice skills learned in school by the participant in a supervised job setting is implemented.

a. A written training agreement between the worksite and MSAS is be prepared for each participant.

b. Each student receives written instruction according to a written and signed training agreement, which coordinates in-school related classes with the 15 hours of on-site training received from the employer.

c. Students will receive pay and school credit for their work.

d. A written evaluation is presented to each student.

Teen parents and pregnant teens gain new knowledge in the areas of parenting and Life Skills. (Scope and sequence enclosed).

Each student attends classes on parenting. The class is taught by the Home Economics teacher and school nurse. The focus of the class will be "Effective Parenting Skills" with particular emphasis being placed on involvement of students in planning the curriculum.

Students can work 3-5 hours a day in the on-site daycare center under the supervision of the Director. Those eligible for JTPA or under "volunteer" status could work more hours if their vocational interest is becoming a daycare provider. Curriculum has been developed so that the students would meet state requirements for certification.

Participants are enrolled in life skills to include consumer buying, food preparation, budgeting, contracts, etc. This class would be taught by the Home Economics teacher.
Students would be encouraged to take classes in Applied Math and Applied Communication.

We are the existing magnet alternative school for the Mat-Su Borough School District.

We have worked with Human Resources Company since the inception of the MSAS. The major goal of our school is to acquire a high school diploma. However, due to age and career goals it becomes necessary to acquire an equivalent diploma. A representative of HRC is on our Teen Advisory Committee.

We work closely with Mat-Su valley JOBS representative. Of the 32 teen parents, 15-22 years of age, we are, or have served, 24. The Jobs representative is our most active referral person, works closely with our school and serves on our Teen Parent Advisory Committee.

The Valley Women's Resource Center is a charter member of our advisory committee. They provide referrals and provide guest speakers to our parenting class. They have a representative on our school and Teen Parent Advisory Committee.

DFYS was our neighbor and provides referrals to the parenting program. They are instrumental in helping our teen parents access various programs such as Medicaid, Food Stamps, Rental Assistance, etc. They have a representative on our Advisory Committee.

Job Service provides vocational testing and job leads for members of our school. They are instrumental in providing vocational information. They have a representative on our Advisory Committee.

The Educational Opportunity Center from the University of Alaska Anchorage provides a half day counselor weekly to help teen parents plan for post high school education.

Life Quest, Kids Are People, Alcoholics Anonymous, and Charter North provide weekly support groups to help our students cope with their many problems.

The Public Health Nurses from Palmer and Wasilla conduct weekly Well Baby Clinics for the babies in our program.

Mat-Su Infant Learning Program screens babies from birth to age three who have special needs, including those who have developmental delays, who are handicapped, or who are high risk.

It is our goal to monitor graduates job placement and/or vocational education programs. Transitional plans from school to work are done on every student at MSAS. We assist the students on future work plans and post secondary training and available community resources. We also utilize telephone surveys and questionnaires. It is also interesting to note that we have had several students who graduated return for extra help and tutoring. This is in part due to our school being small and very personal. Students call, stop by, and write to let us know how their lives are going. We will continue to follow up with our graduates. They have learned that our help does not stop upon graduation.

Graduation with a high school diploma is our ultimate goal. A GED is second best but required due to time expediency on an individual basis.

We will continue to counsel students as to alternatives available after high school and work for mastery in the areas of basic skills. We will help students complete required forms to acquire PELL grants, JTPA funding, scholarships, etc. Most important, we will build individual schedules to prepare students for their career goal. We continue to tutor students after graduation so as to enhance their self-esteem and academic progress. Tutoring is presently helping two (2) teen parents graduates who are pursuing associate degrees. Four teen parents graduates were on the "Deans List" at UAA this past year.

All vocational placements of pregnant and teen mothers are aimed at securing long-term employment. We spend considerable time and resources to match future goals with the job placement. These positions provide each student with a "mentor" to develop job skills and work maturity.

The parenting class will cover basic aspects of Life Skills. The Home Economics teacher will develop and extend curriculum to meet the unique needs of this targeted population group. There are many aspects to be included.

Health and Fitness are of particular importance at MSAS. The direct relationship to quality pre-natal care, diet, stress management, problem solving and physical fitness are being spoken to at this time. We have a low-impact aerobics class for pregnant teens. Exercises have been developed with medical consultation to enhance the physical well being of participants. We have two support groups to help with problem solving and mental health. They are facilitated by trainers from Kids are People, and Peer Helpers. We have a third group facilitated by a group leader from the Mat-Su Council on Drugs and Alcohol. We have a counselor from the Mat-Su Council of Mental Health who comes in 1/2 day a week. She is the school district consultant on Crisis Management. We have a Crisis Response Team at the Mat-Su Alternative School. We have a school hot lunch program that established a food bank this year.

Parenting will be covered in two areas. The first is the classroom program to be directed by the Home Economics teacher and the school nurse. Emphasis will be placed in areas the students see as most helpful. Often this becomes another support group where students provide advice from their own experiences. The curriculum outline is enclosed. The second aspect will be working in the daycare center under the direction of the daycare supervisor. This hands-on experience is invaluable for students.

We have worked very hard to recruit and utilize all elements of the Mat-Su community to build our school and daycare program. They have been instrumental in providing knowledge and resources to improve our program. We not only utilize the above agencies but our Advisory Committee includes members of local government and private industry. Our graduation last Spring reflects that agency and community support. There were 35 graduates and over 900 community members who celebrated this great event. Of the 35 graduates 12 were teen parents. Four more teen parents will have met graduation requirements at the end of summer school.

Incentives have been a part of the environment that helps students succeed. Success on the job and on their academics is rewarding. The ultimate goal is to graduate with a diploma or GED and to have job skills related to a career plan. We will be pursuing grants from private industry for matching funds for all students at the MSAS. We have young parents and pregnant teens who do not qualify under the JOBS Program. Our daycare and incentives provide a means for all these special students to pursue success.

Methodologies Applicable to Rural Areas include the aspect of flexible scheduling, job skills, parenting, life skills, interagency cooperation, diagnosis/prescriptive education, support groups, individualized schedules, vocational testing and placement focus on accountability, focus on cooperation, utilization of computer-assisted education and correspondence study (tutored) HOSTS Program, support groups, advisory groups, and dedication to helping students to work on their own challenges can be duplicated in rural areas.

Our nurse has spent over ten years as a Public Health Nurse in rural Alaska. Our staff is always willing and capable of helping other districts with advice and systems that can be modified to meet local needs of rural Alaska. We have shared information with Wrangle, Sitka, Kenai and Homer. This seems to be the tip of the solution on a state-wide basis. We modify our program as money, staff, facilities, and needs dictate.

We have provided information on our daycare program at several workshops and conventions in the State of Alaska. They have been well received in all settings. Our program would not be what it is today without the Alaska Department of Education who has provided technical assistance and financial support. We hope to become the model "on-site daycare program" for the State of Alaska. We have the experience and dedication to the program to make that happen.

Our goal is to host the third annual Alternative School/Agency Networking Conference in 1994. We had over 100 participants attend. It provided the opportunity for practitioners to meet and share ideas that work for at risk students. This third annual conference needs financial commitment early so plans can be made.

Staff members at the Mat-Su Alternative are educational leaders in the state of Alaska and the country. The staff established and hosted the 1st and 2nd Alternative School/Agency Networking Conferances. This brings together the individuals who work with at risk students. In adition staff memebers and students made the following presentations during the 1992-1993 school year:

1. National School Boards Conference - Anaheim, CA
2. Milken Foundation Seminar - Los Angeles, CA
3. Alternative School/Agency Networking Conference - Wasilla, AK
4. Assistant Principal's Conference - Alyeska, AK
5. State JOB's Conference - Anchorage, AK
6. Rotary Clubs - Palmer/Wasilla, AK
7. Chamber of Commerce - Wasilla, AK
8. Meeting with AFDC & Welfare Reform Directors - Washington, D.C.
9. National Vocational Director's Conference - Washington, D.C.
10. Testimony Alaskan Legislature - Juneau, AK

Awards for Staff Members

1. Teacher of the Year - 1990 - Dr. David Maxwell
2. Educator of the Year - 1992 - Mr. Peter Burchell
3. Alaskan Legislative Proclamation - 1991 - Mr. Peter Burchell
4. Milken Foundation Winner - 1992 - Mr. Peter Burchell
5. Student Representative Alaska Education 2.000 - 1993 - Miss Angela Garnett

Conclusion:

The Mat-Su Alternative School is a model program that has been replicated five times in the state of Alaska. The model of school, community, and agencies working together is a partial solution to the challenges we face as a nation. Dropouts do wish to return to school and get a relevent education that includes academic and vocational preparations. We continue to work with Cities in Schools and the Milken Foundantion to establish accountable alternative schools on a nationwide basis.

PROFILES OF EXEMPLARY SCHOOL-BASED PROGRAMS FOR AT-RISK STUDENTS

TEEN PARENTS/PREGNANT TEENS: A PROGRAM THAT WORKS

(By Peter H. Burchell)

Dear Educator:

I used to be in your school. My name is Jennifer. I was 15 when I left your school. Boys in my life were very important but not like Rick. He was 23 and really cool. He had a car, his own apartment, and lots of money. He sold dope and all of my friends thought he was really cool. He told me how it would be so neat to leave Alaska and go to Florida. We left in the Fall. No more cold winters for this kid. I loved it when I told mom I was leaving. I finally had someone who would protect and take care of me. This was the true love that I had been looking for. We made it to Florida in three weeks.

Life was super. We parked the van on the beach and sold weed to the local kids. I was young enough to hang out at the local high school and sell our stuff. My period was late. The local clinic informed me I was pregnant. Rick didn't seem to be so interested anymore. My baby was beautiful. Shery was the friend I always wanted. Now I was 16 and no where to go. I called my Mom to let her know how I felt. I was shocked to find out she wanted me to come back to Alaska. They had a new school in Wasilla.

I flew home to a new school, old home, and new challenges. I wanted to finish school, get job skills, and go to college to became a nurse. (Ha Ha Ha-you've heard that-no one makes it) I graduated in 1990-had my first year in nursing completed and got a 3.7 GPA for my Freshman year. I graduated from UAA in 1994 with my Associate Degree in nursing. Shery is 5 years old.. You're saying to yourself good for you-but I don't know kids like you. The sad thing is that you are right. We're the ones that quietly leave or worse yet don't. Then we walk down the halls in maternity dresses. We're the ones who withdraw for excessive absences. We're the ones who don't fit in those little student desks. We're the ones who get sick in the mornings. We're the ones who visit the nurse too much (according to the teachers). We're the ones who each day live in fear of not delivering a healthy baby and then becoming a good parent.

P.S. Still got your attention? Great! Let me turn this over to someone who started the Teen Parents/Pregnant Teens program at the Mat-Su Alternative School. He is short, fat, old, and slow which proves that anyone can set up a program to help students like me.

SHORT HISTORY OF THE MAT-SU ALTERNATIVE SCHOOL

The school started in half a portable behind Wasilla High School. It started with a grant and five students.. You had to be 16, a dropout, and behind your class on graduation. There was no telephone, running water, bathroom, or typewriter (forget computer). We got

school district support that Summer-$150,000 for 20 students. The local shopping center (Cottonwood Creek Center) donated a store for the school. We expanded to 20 students. We got our first teen parents. They wanted to come to school, but needed daycare support to come to school and to work. We applied to the Department of Education, Office of Adult and Vocational Education for a grant to start the daycare program. Ms. Karen Ryals, Ms. Sue Ethelbaaugh, and Ms. Naomi Stockdale were instrumental in helping with technical advice and economic support. The program had to meet the needs of the students rather than the students fitting the needs of the school. In 1990 we added our own daycare center. Some of the barriers we had to overcome were misconceptions people held:

MYTH: Teen parents would not return to school.

TRUTH: We have served over 50 teen parents in the last three years. We graduated two teen parents in 1989, and seven in 1990 and 1991 respectively.

MYTH: Teen parents and pregnant teens lack the motivation to complete school and pursue advance education.

TRUTH: Teens know it takes advanced education to get into career fields where they can become economically and socially independent. Sixty percent of our students will be pursuing advanced education.

MYTH: Teen parents and pregnant teens are lazy and don't want to work.

TRUTH: We have helped place over 80% of our teens in jobs. Seventy percent of those are in private employment and 30% are working under the Job Training Partnership Act.

MYTH: The students are unwilling to do the extra work required to catch up and excel after reentering high school.

TRUTH: Eighty percent of the Teen Parents/Pregnant Teens acquire more than the standard six credits per year. They attend our summer school session, take classes at the Mat-Su Community College, and take overload schedules in our school. This, coupled with working three to six hours a day, makes for long days for these special students.

MYTH: The community is unwilling to help these "special students."

TRUTH: We have active letters of agreement from 32 agencies to provide services for our students and their babies. In addition, there are several churches and private individuals who donate time and items to help.

MYTH: These students do not need special programs to succeed. All they need to do is grab their boot straps and get on with their lives.

TRUTH: These students are most often products of dysfunctional families, victims of sexual abuse, and represent the poorest and least skilled segment of the student population in the Mat-Su valley. It takes a well-planned strategy cooperation, and dedicated knowledgeable staff to help these students reach their potential.

MYTH: School districts cannot afford to establish special programs for teen parents and pregnant teens.

TRUTH: This program, like most, requires money. So does a lifetime of welfare, repeated dysfunctional families, etc. The Jobs Program and Alaska Daycare Assistance provide single parents money for daycare. The federal and state governments have become very aware of the costs to the public of subsidizing the lives of undervalued and underachieving parents. These students are very challenging to work with when one considers the psychological, sociological, and educational hurdles they face.

Project Design

The design is both simple and complex. We recruit teen parents/pregnant teens to interview for admission. Upon admission, students develop an academic and vocational program to graduate with the job and academic skills required to pursue their career goal. Students use independent study, correspondence classes, small classes, the integrated learning system, CCC, WASATCH, CSR software on an 80 IBM server, Cooperative Work Experience, and co-credit classes at the Community College to meet their graduation requirements.

The school provides the service required to remove barriers that inhibit students' success in school. We provide a flexible schedule, weekly monitoring of progress, academic appropriate level of work, Mastery of Learning Concepts, tutoring, and advocacy for each student. We continue to bring agency resources into the school to meet their medical, psychological, and social needs. We provide daycare so they have the time and energy to excel on their jobs and in their studies.

We help each student make the transition from high school to adult roles after high school. We emphasize and help them secure post-

high school education via college, community college, vocational school, or apprenticeship programs. We have counseling available to help them explore and finance these alternatives. If they stay in the Mat-Su Valley, we will continue to tutor them at the next level of education.

COORDINATION

One strength of our program has been our ability to recruit, coordinate, and use federal, state, and private agencies in the Mat-Su Valley and Anchorage. Each agency provides direct services to our students. All but four come to the school to work with our students. The agencies and their functions are varied:

1. Medical
   a. Well-Baby Program
   b. Public Health Nurses-Palmer and Wasilla
   c. Planned Parenthood

2. Psychological
   a. Life-Quest-Victims of Sexual Violence
   b. Mat-Su Council on Drugs and Alcohol
   c. Alcoholics Anonymous-Support Group
   d. Adult Children of Alcoholics-Support Group
   e. Starting Point-Drug Evaluations programs
   f. Charter North-Drug Evaluations
   g. Kids are People-Support Group

3. Food and Housing
   a. ASHA
   b. AFDC
   c. DFYS
   d. Local churches for our Food and Clothing Bank
   e. Alaska Food Bank

4. Legal
   a. Alaska Department of Juvenile Justice and Probation.
   b. DFYS

5. Jobs and Careers
   a. Job Service
   b. JTPA
   c. Department of Vocation Rehabilitation
   d. Educational Opportunity Center
   e. Alaska Department of Education
   f. Alaska Apprenticeships Program

Do I have to recruit all these people? No. However, they are super people and have access to resources and information that you don't. Our experience is that the more people you get involved in the solution, the easier and better the solutions become. Even Mother Theresa recruits help. Will agency people help? Most will; they are willing and capable.

INTERVENTION STRATEGIES

Teen parents drop out of school at a rate of 80-90%. They represent the lowest economic group in the country. The simple fact is that the needs of teen parents/pregnant teens are more severe than the "normal" student. Thus, the program to help them requires additional features to meet their needs.

The first is the alternative school itself. We have an open entry and open exit program that students can enter any time over a twelve month school year. They exit when they have the required credits and their job skills.

The second is that the curriculum is delivered through a variety of methods: correspondence classes, an integrated learning system on the computers, independent study contracts, cooperative work experience, and dual credit classes with the Mat-Su Community College. Student abilities and learning styles are considered in scheduling academic experiences.

The third aspect is the hours of operation. We open at 7:00 a.m. and close at 5:30 p.m. The students schedule in three hours a day at a minimum. They work three to six hours a day, depending on economic need and career aspirations. We are open 12 months of the year.

The fourth critical component is our support groups. Our students come with many psychological and social problems. We have four support groups that meet weekly: Alcoholic's Anonymous, Kids are People, Victims of Sexual Abuse, and Adult Children of Alcoholics. These groups provide our students with an understanding of the origin of their problems and important alternative strategies for dealing with these problems. Local agencies provide group facilitators who co-facilitate with a school staff member. The next group of players are the teachers/advisers. These special teachers have the knowledge and skills to help these students reach their academic potential. They teach, tutor, check progress, schedule classes, refer problems to agencies, work directly with job sites, and serve as general advocates for their advisees. This direct contact and ownership is reflected in our students' high success rate.

The fifth critical aspect is the Life Skills and Parenting Class. This class meets twice weekly under the supervision of our Home Economics Teacher. It explores the various aspects of being young parents and the challenges they face. This provides focus on the student as worker, consumer, parent, intimate partner, etc.

The next key player in our program is the school nurse. This person coordinates the various agencies' representatives and recruits new ones. The nurse serves as a front line medical adviser to the pregnant teens and teen parents. Experience in public health enables

the nurse to plan and evaluate health care with individual students, referring them to appropriate agencies and private health care professionals.

Our case manager is responsible for networking local and state agencies. She gets services to students. We have extended our agency network to include 34 separate agencies.

The students have supervisors on their respective job sites. These individuals serve as "occupational mentors" and provide support and motivation outside the school setting. There are several examples of this support motivating students to pursue higher education. On the job they provide structure so students get the job and work skills necessary for them to compete in the world of work. Over 50% of the mentors attended graduation this Spring. The common response was "This is my kid graduating, and I wanted to be part of the celebration."

At this point, the key question is "Are you still interested in this challenging aspect of education?" There has to be a touch of insanity to get involved in this kind of program. You have to be ready for young parents calling in the middle of the night to get advice on medical problems or to contact the authorities to have a boyfriend arrested for assaulting your student. The students share intimate information on lesions, tubal ligations, and other medical aspects you may know nothing about and hoped you would not have to learn. However, if it were your son or daughter going through these trials, would you want a program like this to help them?

DAYCARE CENTER AND SERVICES

We operated the first two years using local daycare centers. We paid the daycare costs and provided a stipend for transportation expenses. The Mat-Su Valley is huge and we did not have a school van. We got funding through a grant administered by the Department of Education, Office of Adult and Vocational Education. This year we have our own licensed daycare center within the school. We have a 20 crib center with early childhood education. We have a director, assistant director, and student workers. This is an exciting program. We purchased some furniture and the inmates at the Palmer Correctional facility built the rest. The in-school center relieves much stress for young parents. They can stop work or school to check on their children. The funding for the program comes from many sources. The school district provides a van driver, coordinator, teacher/advisor, facilities, and administration. Most importantly, they provide the support needed for planning, implementation, and growth of the program. Dr. Sorenson has been instrumental in this process. We have funding from the Department of Education via Carl Perkins grants. Ms. Naomi Stockdale has been our contact person and advisor. The grants helped purchase furniture, staff time, transportation costs, curriculum costs, etc. The

costs for a twelve month school year with over 40 babies was $87,000.

The flip side to this record is all students are a revenue source. Each student who returns to school or does not drop out represents $3,500 to $19,500 to the state of Alaska under foundation funding. If you have the cooperative work experience program, each student counts in the Vocational Funding. Our experience has been that 15-25% of the students will qualify for Special Education funding. In our district, five percent qualify for migrant education funding. The Jobs Program under the Labor Department or the Alaska Day Care Assistance program will pay the cost of daycare and transportation for qualified students. In the Mat-Su Valley that is $465 per month for daycare.

We have operated our Teen Parents/Pregnant Teens program with two to 45 students over the past five years. Each size presented unique challenges. The important thing is not the size of the program. The important thing is whether your program is a success for those students enrolled. Does it provide the services to help young parents stay in or return to school to gain the academic and social skills required to be a successful parent and citizen?

CONCLUSION

A program for teen parents and pregnant teens is challenging to establish and maintain. Don't let anyone fool you. It is tough, demanding, soul wrenching, and time consuming. If you try to do a solo flight you and your teen program will crash and burn. If you recruit willing help, your program will grow and improve. If you wish to start a program, call us; we have made the mistakes and are in the process of improving each year.

School Motto:	Poverty stinks.
School Solution:	Working together brings success.
School Philosophy:	Our altitude will be set by our attitude, not our aptitude.

SUMMARY STATEMENT OF HON. JOYCELYN ELDERS

Senator HARKIN. We will call as our first witness the Surgeon General of the United States, Dr. Joycelyn Elders. Dr. Elders, welcome back again to the Appropriations Committee. We have a copy of your full statement and it will be made a part of the record in its entirety. Again, we welcome you.

Teen pregnancy is an issue I hear a lot about in Iowa and all over this country. It is an issue that alarms us. It is an issue that bedevils us too because we do not know why. I have seen more charts and I have listened to Senator Moynihan—God love him—for years, and I still cannot find out why. I do not know if there is any one reason, but what are the reasons?

Dr. Elders, the floor is yours. Please proceed as you so desire.

Dr. ELDERS. Thank you, Senators Harkin, Specter, and Stevens, other members of the Labor, HHS, and Education Appropriations Committee. I am delighted to be here to talk about adolescent pregnancy and childbearing. I especially want to address the impact it has had on our young people, as well as society in general.

Adolescent pregnancy and childbearing are important issues for all of us. I think just as the statements you have made and the charts before us demonstrate, adolescent pregnancy is an important issue because of its link to poverty, welfare, dependency, child health, violence, prisons, and other domestic issues.

The link between teen births and poverty is clear. Children born to children less than 18 years of age who do not finish high school and are unmarried have an 80 percent likelihood of being poor. In contrast, only 8 percent of children born to women older than 20 who have finished high school and married are poor.

In the United States each year, as you have said, more than 1 million adolescent girls, 1 in 10, become pregnant; 4 out of 10 white girls will have a pregnancy before the age of 20, and 6.7 out of 10 black girls will have a pregnancy before the age of 20; 4 out of 5 of these pregnancies are unintended. Approximately 48 percent will end in births, 40 percent in abortions, and 12 percent in miscarriages.

In 1992 the cost of teenage pregnancy just for AFDC, food stamps, and Medicaid was $34 billion.

While the pregnancy rate for adolescents was relatively stable through the 1980's, the birth rate began to rise in 1986, as your charts show, and has reached a level not seen since the early 1970's. This increase has been greatest among our young adolescents. The birth rate for 15 to 17 year olds increased 27 percent between 1986 and 1991 as compared to an 18-percent increase for 18 to 19 year olds.

Adolescent pregnancy and childbearing depends on a number of factors. Included among these are poverty, race, educational achievement, age of menarche, sexual activity, and the availability of educational and contraceptive services.

The proportion of adolescent girls who are sexually experienced has increased from 28 percent in 1970 to more than 50 percent in 1988. Most disturbing, this increase is sharpest for young adolescents. The proportion of 15 year olds who are sexually experienced has increased fivefold since 1970, from 5 percent to nearly 26 percent. Poor minority adolescents are more likely to be sexually active than their white counterparts. Their use of contraceptives is lower and their pregnancy and birth rates are higher.

These differences, however, have been narrowing. When we look at the white unmarried birth rate, we find that from 1970 to 1991 there was a 244-percent increase in the birth rate for unmarried white teenagers as compared to a 47-percent increase for black teenagers. Nevertheless, the black rate is still twice as high and the adverse consequences of adolescent childbearing fall disproportionately on young, less well educated, poor minority women.

Adolescent birth rates in the United States are much higher than those in western European countries; I feel this is very well demonstrated by the chart that you have on the wall.

Attempts to prevent adolescent pregnancies have taken several different forms: sexuality education, abstinence education, life skills education, contraceptive education, and contraceptive services, both singly and in combination.

Today's statistics suggest our slingshot approach to this multifaceted problem that is destroying our adolescents has not worked. We must move to a more community oriented, family centered, comprehensive, integrated approach that includes not only our schools, but our churches, all of our community, as well as the mass media.

We must provide early childhood education in programs such as Head Start. I know you have just approved that program, and I think it is wonderful. We know that children who have had 1 year of Head Start have a 50-percent reduction in teen pregnancy rates. They are 37 percent less likely to go to prison and 82 percent more likely to finish high school. We must have a comprehensive health education program beginning with kindergarten that begins to address the needs of all of our children. This is a place where we can make children equitable.

We know that we cannot make sure that all of our parents teach the same. We must begin to educate our parents and involve our churches as well as our schools. We must teach our young men responsibility. We have allowed too many of our young men to donate sperm and feel that that was equivalent to being a father. Hopefully in welfare reform, we will do everything we can to make sure two parents are involved as opposed to just one.

We must begin to look at full-service schools for our poorest communities, and this is a part of our health care reform, to make sure that our young people will have access to education and services.

Last, we have to offer our young people hope. I know you have done that with some of the youth service programs which you have already passed.

Senators, we all know too well the problems associated with adolescent pregnancy. Our high levels of adolescent pregnancy, abortions and births are a national embarrassment. We know it is better for our young people to delay sexual activity and we could help them to do so. We also know that when they do become sexually active, they need contraceptives to protect them against pregnancy and sexually transmitted diseases. We know that we cannot legislate morals. We must teach responsibility. We must all work together to create the kind of society where all children can be planned and wanted and have the opportunity to grow up healthy, educated, motivated, and with hope.

PREPARED STATEMENT

I would like to close with an old Greek proverb that says: "A society grows great when old men plant trees under whose shade they know they will never sit." I hope we are able to plant trees for our bright young people of the 21st century to sit under.

Thank you.

[The statement follows:]

STATEMENT OF M. JOYCELYN ELDERS

Chairman Harkin, Senator Specter, and members of the subcommittee, I am delighted to be with you today to talk about adolescent pregnancy and childbearing and the impact it has on our young people, as well as our society in general.

Adolescent pregnancy and childbearing—their causes and their social and economic consequences—are among the most important domestic problems facing our Nation. As you know, I have long been fighting to bring the necessary attention to these problems—and to marshall the resources and the collective will to do something about them.

Let me make this point clear—I believe in abstinence. Every parent I know, every teacher I know, every preacher I know—we all believe in abstinence. It is an important component in addressing the problem we are discussing today.

ADOLESCENT PREGNANCY AND CHILDBEARING

In the United States, one million adolescent girls—one in ten—become pregnant each year. More than 80 percent of these pregnancies are unintended. Approximately 500,000 give birth. While the pregnancy rate for adolescents was relatively stable through the 1980's (we have data only through 1988), the birth rate began to rise in 1986 and has reached a level not seen since the early 1970's. More of this increase has occurred among younger adolescents; the birth rate for 15–17 year olds increased by 27 percent between 1986 and 1991 as compared to an 18 percent increase for 18–19 year olds.

Levels and changes in adolescent pregnancy and childbearing depend on a number of factors. The rapid increase in adolescent sexual activity observed during the past two decades is among the most important of these. The proportion of adolescent girls who are sexually experienced has increased from less than one-third to more than one-half. Most disturbingly, this increase is sharpest for the younger adolescents—the proportion of 15 year olds who are sexually experienced has increased five-fold since 1970—from five percent to nearly 26 percent.

Another factor we must keep in mind is the longer interval our young people spend at risk of adolescent premarital pregnancy; over the past century this interval has increased by about three years. This is accounted for by two factors. The first is that young men and women become physically able to cause or sustain a pregnancy at earlier ages than in past years. The second is that the age at first marriage has increased, due to changes in social norms and trends toward more years of schooling.

If there is any good news on the topic of adolescent pregnancy, it is that although the consistent and effective use of contraceptives by sexually active adolescents is far from adequate, adolescents have increased their use of contraceptives somewhat and this, in turn, has kept adolescent pregnancy rates relatively level despite large increases in the proportion sexually active. During the 1980's, the proportion using a contraceptive method at first intercourse increased from 53 percent to 65 percent. When pregnancy rates are calculated for sexually active adolescents only, the 20 percent decrease observed during the 1980's clearly shows the effect of increased contraceptive use.

It may be possible to further increase consistent contraceptive use by adolescents with the introduction of more "user friendly" contraceptives such as Norplant and Depo Provera. Unfortunately, current pricing on these methods is so high that they are simply out of reach for most adolescents. Another consideration, especially for adolescents with multiple or serial partners, is that these and other non-barrier methods offer no protection against STD and HIV infection.

The legalization of abortion corresponded with a decline in adolescent birth rates during the early and mid-1970's. Abortion rates for adolescents continued to rise during the later half of the 1970's, but have increased only slightly since. Similarly, after the increases observed during the 1970's, the proportion of adolescent pregnancies terminated by abortion has remained at about 40 percent since 1980.

Levels of adolescent sexual activity, contraceptive use, pregnancy and childbearing vary by race. Black adolescents are more likely to be sexually active than their white counterparts, their use of contraceptives is lower and their pregnancy and birth rates are higher. These differences have been narrowing as most of the increase in sexual activity, pregnancy and childbearing has been for white adolescents. Nevertheless, the adverse consequences of adolescent childbearing fall disproportionately on black women.

Thus far, I have been discussing adolescent pregnancy in terms of numbers and trends, but there are other aspects. The social and economic costs of premature parenthood are enormous. Adolescent childbearing has long been associated with reduced educational attainment and employment opportunities. In turn, poverty and

AFDC dependency are more prevalent in families begun by adolescents, particularly those that are unmarried. In 1992, an estimated $34 billion was expended on AFDC, Medicaid, and Food Stamps for families begun by adolescents. Moreover, the children of adolescent parents are more likely to become adolescent parents themselves, perpetuating the cycle.

Other social factors must also be considered as having an effect on adolescent sexual and fertility related behavior. Today, some believe that too many adolescent pregnancies and births are intended, or at least that the adolescent is indifferent when an unplanned pregnancy occurs. When life opportunities are limited, an early unplanned pregnancy may not be viewed as an obstacle to success and a child may be considered an asset to someone who lacks hope for the future. A family background of low educational attainment, low-income or welfare dependency may be more a predictor of early parenthood than a consequence of it.

COMPARING THE U.S. EXPERIENCE WITH OTHER COUNTRIES

When adolescent birth rates in the U.S. are compared with those for Western European countries similar in culture and level of economic development, it is clear that U.S. rates are substantially higher. Induced abortion rates for adolescents and, by extension, pregnancy rates follow the same pattern. Levels of sexual activity, however, are very similar.

In Western Europe, governments have recognized the need for adolescent contraceptive services and have acted accordingly. Contraceptive services tend to be more accessible to adolescents, as well as confidential and low cost. In some cases, there are clinics set up specifically for adolescents and young adults.

While comprehensive sexuality education in Western European schools is not universal (except in Sweden), the mass media, either controlled by or in cooperation with government, has widely disseminated information about contraception and responsible sexual practices.

Superior access to services and education appears to translate into higher contraceptive use for European adolescents when compared to those in the U.S. While the United States may not choose to adopt these policies wholesale, we can learn from the Western European experience. It seems fairly clear that sexuality education, access to contraceptive services, and responsible treatment of sexuality by the media can increase contraceptive use by adolescents, and that this increased use can result in lower rates of too early pregnancy, abortion and childbearing.

SUCCESSFUL INTERVENTIONS

Attempts to prevent adolescent pregnancy have taken several different forms—sexuality education, abstinence education, life skills education, contraceptive education and contraceptive services programs—both singly and in combination. Evaluations of these programs indicate those that combine education with information about, or access to, contraceptive services show the most promise of success in both delaying onset of sexual activity and preventing unplanned pregnancies.

Beginning in the 1980's, the primary Federal focus on adolescent pregnancy prevention was abstinence education. Delay of first intercourse is important because an older age is positively associated with more stable relationships, fewer partners, and an increased likelihood of contraceptive use. Where first intercourse occurs early, contraceptive use is less likely and pregnancy risk higher. However, information about—and for older adolescents, access to—contraceptives is an essential component of any program developed to effectively reduce adolescent pregnancy.

The Postponing Sexual Involvement curriculum, developed at Emory University and the Reducing the Risk curriculum, developed by ETR Associates, combine sexuality education, including delaying sexual involvement, social skills training and practice in applying skills with comprehensive information about contraceptives. These programs have shown positive effects on delaying first intercourse, increasing the use of effective contraception at first intercourse and decreasing the frequency of unprotected intercourse.

The success of service approaches also seems to be coupled with other interventions such as focused educational or counseling components. Douglas Kirby recently completed an evaluation of six school based clinics and found that providing contraceptive services alone was not enough to increase use. Rather, increases in contraceptive use were observed in those clinics where the associated school had a strong educational program on prevention issues. Another program, the Self Center, a school-linked clinic affiliated with the Johns Hopkins University, provided medical and contraceptive services, as well as sexuality education and individual and group counseling, to students in two nearby schools. Evaluation results indicate that in

addition to increasing contraceptive use and decreasing pregnancy, initiation of sexual activity was delayed an average of seven months.

FEDERAL PROGRAMS

There are several Federal programs that provide pregnancy prevention services but only two that focus directly on adolescent pregnancy prevention—The Title X Family Planning Program and the Title XX Adolescent Family Life Program.

The Title X program was enacted in 1970 to provide support for public and private nonprofit agencies in the provision of voluntary family planning services for low-income individuals. More than 4 million clients receive services through a network of over 4,000 clinics each year. The majority of Title X clients are low-income women and approximately one-third are adolescents.

Rising sexual activity rates among adolescents, recent increases in the number of adolescents and older women who need subsidized services and concerns about prevention of sexually transmitted diseases (including HIV) have increased the need to expand family planning services. Priority initiatives for the Title X program include:

—Outreach to low-income women, adolescents and persons at high risk of unintended pregnancy or infection with STD not now receiving family planning services;

—More emphasis on prevention of adolescent pregnancy, including enhanced counseling as well as new service arrangement for providing services to adolescents;

—Increased focus on quality and completeness of services including treatment of STD's, screening for cervical cancer and breast cancer, substance abuse counseling and counseling on avoidance of high risk behavior which may place clients at risk of STD and HIV;

—Expansion of current clinic sites and development of clinics in high need areas to provide services to an additional 500,000 clients per year;

—More emphasis on training and retention of Family Planning nurse practitioners and those working in clinics that serve high need populations.

The Title XX Adolescent Family Life program was enacted in 1981. The program has provided funding in three areas: (1) care demonstration projects that serve pregnant and parenting adolescents, their infants and their families; (2) prevention demonstration projects that provide abstinence education services to preadolescents, adolescents and their families; and (3) research projects on the issues of adolescent sexuality, pregnancy and childbearing.

In fiscal year 1995 we are proposing transferring Adolescent Family Life funds into a newly created Office of Adolescent Health. The authorizing legislation for the Office of Adolescent Health will allow us to approach adolescent health issues from a much broader perspective than that of the Adolescent Family Life program. Prevention of adolescent pregnancy will remain a priority but will be approached using a broader strategy than just abstinence alone. Programs now funded under Title XX will be eligible to compete for funds under the Office of Adolescent Health.

HEALTH CARE REFORM

Included in the President's proposed Health Security Act and other committee markups are two components of which I am especially proud and which are particularly pertinent to the current discussion—comprehensive school health education and school-related health services.

The first provides authority for the development of comprehensive health education programs in the schools. A sequential, age and developmentally appropriate approach to school health education would provide every child with a foundation of knowledge for risk reduction and health promoting behaviors. Ideally, a comprehensive health education program would take an "all risk approach" and provide prevention information on many related health topics—growth and development, nutrition, safety, first aid, injury and violence prevention, environmental health, tobacco and other substance abuse, disease prevention and control, mental and emotional health, family life and human sexuality.

The second provides school-based health services. School-related health services are logical partners of comprehensive health education in that they can increase access to primary and preventive health care. Current proposals target areas with the highest need as demonstrated through high rates of poverty, adolescent pregnancy, sexually transmitted diseases, HIV infection, substance abuse, community or gang violence and unemployment. In communities with high adolescent pregnancy rates, there is no doubt that family planning must be a component of these services.

CONCLUSION

The problems associated with adolescent childbearing are well documented, the continued high levels of adolescent pregnancy, abortion and births are a National embarrassment, and we know that we have done very little of real substance to address this issue. We know it is better for our young people to delay sexual activity and we should help them do so. We also know that when they do become sexually active they need contraceptives to protect them against pregnancy and STD's.

There are a number of obstacles to successful contraceptive use by adolescents, some are related to access and some are psychological—reluctance of adolescents to admit their sexually active status or the notion that intercourse is more acceptable if it is spontaneous. Increasing access to contraceptive services for adolescents is necessary, but will not be sufficient by itself. We need to develop and implement more education and outreach efforts. By reaching adolescents in their own environments to resolve myths and fears about sexuality and contraceptives, as well as provide information about availability and location of services, we can begin to reduce our disturbingly high levels of adolescent pregnancy and childbearing.

PRESSURE TO BECOME SEXUALLY ACTIVE

Senator HARKIN. Well, Dr. Elders, thank you very much. That was just a great statement.

I have a number of questions and I would like to get into them. You have raised a number of thoughts in terms of responsibility, young men, welfare reform. We can get into those.

I had a number of field hearings last year on welfare reform around the country. I always insisted that we have a number of teenage parents at each one of these welfare reform hearings. One of the things that struck me in every one—I had hearings in Los Angeles, Detroit, Newark, and Atlanta—was the fact that these teens said they felt pressured into becoming sexually active. It was the thing to do. Sometimes having a baby was a status symbol. I am just wondering about that. How do we attack that? I heard that from everyone.

I asked these kids what they did in their spare time. Well, they watched a lot of TV. Well, what TV? MTV and soap operas. I am not much of a TV watcher, but every time I have turned on a soap opera or MTV, there is some sexual connotation there. Someone is engaged in sex or something has overtones of sexual activity to it. I am thinking if this is what these kids watch every day from the time they are 9 or 10 years old, then I can see how they feel they are pressured. Everything is telling them that it is good, sex is great, it is wonderful. You ought to do it and enjoy it. It is the thing to do. It is a status symbol because what they see on television are all these people that are powerful and well-dressed and doing great things, and obviously they are very sexually active.

So, I am just wondering what kind of strategies we might pursue to try to turn this around. I see you nodding your head, but I am just wondering, am I over-reacting? Am I overemphasizing this?

Dr. ELDERS. I agree with everything you are saying, Senator. Years ago, being from a very poor, rural farm State, we were obviously working and we did not even have a TV. So, things were very different. We did not have cars to get across town and back in a few hours, and usually we were with our parents or they were home with us. So, all of those things have changed very greatly for many of our young people.

We have got to educate them and teach them how to deal with the problems that they are seeing, and we have not done that. We

have depended on parents to do that, and Senator, we have never educated parents.

ROLE OF TELEVISION/MASS MEDIA

Senator HARKIN. Let me just ask a very explicit question. Do you believe that the media has contributed to the problem of unwanted teen pregnancies?

Dr. ELDERS. Yes; there is no question, Senator. We do not want the schools to educate the children. We do not want the teachers to educate them, but we feel it is all right for the streets, the girlie magazines and the TV. Your TV has the same thing that my TV has on it. Everything.

Senator HARKIN. Obviously, every time we get into that area, we run into first amendment rights, freedom of speech. No one wants to trample on first amendment rights and the right of the media. It is always a very touchy area to get into. I just do not know. Again, I am looking for suggestions and ways that we might approach this on a national basis.

I think those who sponsor such programs, the sponsors themselves, do so because people watch them.

Dr. ELDERS. That is right.

Senator HARKIN. They say people want to watch that, so we will sponsor it.

Dr. ELDERS. Senator, one of the best things that happened to me as a health director in Arkansas was what a media person told me—we were talking and he was trying to help. He told me, "Dr. Elders, I can reach more people in 30 seconds than you will in 30 years," and that is very true.

But one of the things that TV mass media did, they came and said we want to work with you to try to put on a program for the State of Arkansas. Well, they really came and they really worked hard. The owner of the station worked very hard, and, of course, they won the Emmy, the Oscars, the Edward R. Murrow, all of the awards for the best program on the adolescent pregnancy problem—bringing attention, making the community aware of this problem. You go to Arkansas and ask—well, what is the major health problem? Everybody in Arkansas would say teenage pregnancy. I told them I did not know whether it was or not, but obviously our problem is very great.

We need to talk with the mass media and see if we can reduce some of what is there, but I think that we need to begin to use the mass media in ways to help us address our young people and make programs like that available for parents and young people and for communities. They know how to do a very good job with that.

Senator HARKIN. They sure do.

RESPONSIBILITY OF YOUNG MEN

Two other things. You mentioned responsibility. You mentioned young men. One of the things we grapple with here, it just seems that many of the programs dealing with teen pregnancy are always focused on young women. Do you have any ideas as to how we should address this problem with young men?

Dr. ELDERS. I think again that we need to make sure that we have the comprehensive health education program starting very early and teaching them about responsibility.

But the other thing that I think we really need to do is in our family planning clinics—Senator, we have not involved the young men. Even if they came in with their girlfriends, we would leave them sitting in the waiting room while their girlfriends received services and counseling. So, we really need to begin to reach out and make a conscious effort to involve and educate our young men.

The other thing is we started putting the Social Security card numbers of the fathers on the birth certificates.

Senator HARKIN. You did that in Arkansas?

Dr. ELDERS. Arkansas. When I would go around to schools talking and tell the young men that, they may have ignored everything else I said, but all of a sudden they stood up and they really started listening. The thing that made me really think about that is when a young man told me, "Dr. Elders, I always use a condom when I have sex with my girlfriend. It is those other old girls."

Well, of course, it was those other old girls that we are paying for and when I made them aware that we are going to put your Social Security card number on the birth certificate and we are going to deduct 17 percent of your salary off the top whenever you work, all of a sudden it became a real issue because they were not interested in paying for this other issue. They do listen and they have listened very clearly to that message. As I say, when I go around the country and talk, that is the one thing I always get a big cheer from.

Senator HARKIN. Good for you. Senator Bond and I have introduced a welfare reform package. There are a lot of them floating around up here. But one aspect of our bill is to take what you did in Arkansas and put it nationally under the IRS system so that as soon as parentage is established, the young man in question, the parent, if fatherhood is established, no matter where he goes, no matter where he works, if he has not provided child support, it will be deducted from the IRS. So, he cannot hide. He can go to another State. He cannot hide. I think if young men start getting that message, that they cannot escape, I think that will start building in some responsibility.

Dr. ELDERS. I certainly think that you are right. We did not have a hard time getting the Social Security card number while the young woman was pregnant. The young men were very proud of that. They would come in and they readily gave it. However, we feel if we waited 2 years later, it would be a major problem. Our person in vital records said we were getting about 90-plus percent of Social Security card numbers—we were getting it for everybody, the marrieds and the unmarrieds.

Senator HARKIN. The only problem is if they leave the State of Arkansas.

Dr. ELDERS. Yes, sir; that is true.

Senator HARKIN. That is why we need a national program.

Dr. ELDERS. Absolutely.

Senator HARKIN. Thank you, Dr. Elders.

Senator Specter.

Senator SPECTER. Thank you very much, Mr. Chairman, and thank you, Dr. Elders, for joining us at this hearing.

TELEVISION ADVERTISEMENTS

Picking up for just a minute on a line of questioning by the chairman with respect to the media, there were some interesting comments by Judy Muller on television pointing out that she has seen the ads. One was a teenage girl resembling Brigitte Bardot depicted in various provocative positions in the back seat of a car, entangled with a mustached, middle-aged man, blouse unbuttoned, skirt riding up, was not even wearing jeans. In fact, there was not a single pair of jeans anywhere in the ad.

Then another situation which she characterizes as post-traumatic-denim disorder when she is driving down Sunset Boulevard and there towering over traffic on an enormous billboard a young man and a woman, young people, in the process of pulling down one another's Calvin Kline's, motorists breaking left and right, startled by these half-naked adolescent giants in a state of perpetual heat.

Now, we talk about advocacy of morality, of leaders speaking out, parents training by example, and we wonder how those positive messages can compete with these messages. We will hear later from teenagers about positive peer pressure, but we wonder about our ability to deal with this kind of message on the street and on television.

I ponder it on the legalities being very much dedicated to the first amendment, freedom of speech, press, radio, television, and wondering how we cope with it. There may be a clear and present danger to traffic safety by these ads. Seriously. Or there may be a clear and present danger to the health of teenagers who see these ads and cannot digest them and cannot understand them and cannot resist them.

My question to you is, moving aside the legalities for the Congress, what do you think the impact of these provocative ads is on stimulating direct, individual conduct which results in a teenage pregnancy?

Dr. ELDERS. Senator, I think that it certainly has a very—well, I think it certainly stimulates young, underprivileged youngsters. They often do not have parents who have been able to give them the background to make informed decisions, to be able to see these ads as what they are, and that this is not what everybody in the world is doing. It is a real problem.

ROLE OF PARENTS

Senator SPECTER. When you talk about parents, that is the central matter. My brother and my two sisters and I would not have considered doing anything to embarrass our parents, both of whom were immigrants who worked so hard for their children in an era of depression, but we had parents.

Now, we start on teenage pregnancy without parents because it is singular at best. You do not have parents in the plural, and the one parent which the infant has is a teenager. What do we use as a substitute for parental guidance?

Dr. ELDERS. Senator, we know that many of our children are growing up in dysfunctional homes. This means that for those children, if we want to save our society, we will have to do more. My parents were very poor, but I had two parents and they were always there.

To do more, I feel that we have to put in more programs that will help the youngsters from dysfunctional families. They need many different things, and this is why I feel so strongly that we have to have early childhood education. We have to have day care. We have to have parent education. We have to have comprehensive health education. We have got to do all of those things. Senator, it is far, far cheaper than prison.

Senator SPECTER. Well, I was very much impressed with your statistics on Head Start, as you enumerate, the reductions in teen pregnancies and the reduction in those who go to jail, and the greater earning capacity.

Dr. ELDERS. Yes; 39 percent less likely to ever need welfare.

HEALTH EDUCATION

Senator SPECTER. That brings up the question. You talk about health education which is a safer statement than sex education because when we talk about sex education, immediately red flags go up. I talked to you informally before the hearing started about the basic point of instructing young, pregnant women about prenatal care. I personally see no reason why not if there cannot be an issue of making them promiscuous. They are already pregnant. Four prenatal visits and you eliminate most of the problems of low birth weight babies. Why not, Dr. Elders? Why should not every school in America which comes into contact with young women who are pregnant tell them at least about prenatal care?

Dr. ELDERS. Senator, I would like nothing better. I am one of those people that very strongly advocate a comprehensive health education program from K through 12 and school-based health services that offer and provide prenatal care. I am about preventing pregnancy, but if the young woman gets pregnant, I feel that she needs to have absolutely the best in education and prenatal care. It is far cheaper to pay for prenatal care than it is to pay for a very low birth-weight baby who may cost upward of $200,000.

Senator SPECTER. Well, all of us in public life are very reluctant to make provocative statements which get us into trouble. That is something which goes without saying and most of us do not want to say it even though we all know it is true. But I have at least passed the point on being willing to say prenatal care for pregnant young women.

You made the statement about when teenagers are sexually active, they must have contraceptives. That is a pretty brave statement, so let us talk about it for a minute.

I had a call-in show last night. I do a monthly TV cable call-in show and we talked about this subject. I have done a lot of them and I have not been as uncomfortable on any as I was on the one last night——

Dr. ELDERS. Sorry. I did not see you.

Senator SPECTER [continuing]. Because I was inviting the tough questions, the questions that were very dangerous to answer hon-

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estly. Everything I said was true but I do not know if I said enough, if I said everything.

The statistics on active teenage pregnancies—I am looking through them in my compendium of excellent staff work which is so good I cannot find them. My recollection is that by the time boys leave high school, it is 88 percent sexually active——

Dr. ELDERS. That is correct.

Senator SPECTER [continuing]. Seventy-five percent for young women who leave high school. Now, when we face that kind of sexual activity, I have two lines of questions.

ABSTINENCE

One line of questions is on the abstinence program, and the Adolescent Family Life Program, which received $7 million in 1994, has been eliminated and there is $6.8 million being allocated to the Office of Adolescent Health.

One of my colleagues elected in 1980 was Senator Jeremiah Denton of Alabama who is very strong on the issue of abstinence, the program of the Adolescent Family Life Program. When he did not return in 1987 involuntarily, I have taken up his program and tried to promote it.

I do not know if you know why the program was cut, but I would be interested in your observations as to the value of abstinence and how at the start, before we talk about contraceptives, how we make as strong a case as we can for abstinence.

Dr. ELDERS. Senator, I think that every person I know, every mother I know, every minister I know, every teacher I know, all support abstinence. The way to teach abstinence is to start very early indoctrinating our young people.

Senator SPECTER. How early?

Dr. ELDERS. Well, the earliest we can always start is kindergarten, but I would say as early as the need to know.

One of my doctors told me—we were talking the other day, and she has 4 year old twins. Obviously her children had seen something on TV and said, "Mommy, I want you to pull off your clothes and dance with Daddy." This is a 4-year-old. I am just saying that other people's 4 year olds see the same thing. So, I am saying the need to know is probably starting earlier now than it used to.

Senator SPECTER. You saw that on television?

Dr. ELDERS. No; the doctor's 4-year-old had asked her to do that. I am saying that I am sure the 4-year-old probably saw something on TV. It is not hard to see something like that on TV, at least on my TV. I am just saying that is a problem.

The abstinence program—what I feel we need is an adolescent health program that involves multiple issues—things like drugs, alcohol, violence, AIDS—all the things that are involving our adolescents. I feel that the Office of Adolescent Health should be a more encompassing office to address all of the needs of our adolescents rather than just a single issue. HHS is very committed to working with other programs and supporting and teaching abstinence.

I think the Adolescent Family Life Program had more than just the abstinence program, it had a care program for pregnant and parenting teens. I think some of those programs are really very excellent. We had one in Arkansas. It was called A Plus Program;

they provided day care and other things. So, certainly those were very good things. But, Senator, those were pilot programs, and obviously $6 million was not enough to address the needs of the number of adolescents we have in our society.

Senator SPECTER. Well, I am hopeful that we will be able to maintain the Adolescent Family Life Program at least at $7 million and maybe a little for inflation on the abstinence issue and then add some other funding in for the kind of activities which you describe beyond abstinence, which I think are very valuable.

Dr. ELDERS. Yes; adolescent pregnancy prevention and family life education will be an integral part of the Office of Adolescent Health, but I think that we definitely need to expand that and include adolescent health. Otherwise, I feel we will not make progress.

Senator SPECTER. All right. Then we make our maximum effort of abstinence that we can, and then we find that teenagers are sexually active and it is really no surprise. We have your statement about they must have contraceptives, and we have the issue of leaving it to the local school boards to make the decision as to what they are going to do by way of schooling. If there is any advocacy of that issue, it is not a hot potato. It is a nuclear blast to make any advocacy of that position.

ADDRESSING TEENAGE PREGNANCY

So, what do we do? And we add to the issue of teenage pregnancies and the enormous problems on welfare costs, on crime control, on education, on disintegration of the family unit, and then you add into that the health issue of AIDS and sexually transmittable diseases and where do we go on leadership in America on the subject of contraceptives?

Dr. ELDERS. Senator, I feel that the leadership, like yourself, in America should begin to address the needs of our adolescents, whatever they are, because one way or the other, we are paying very dearly for not addressing them. We have tried ignorance, Senator. It is time for us to try education. We spend an average of 43 hours teaching our children about their bodies and about good health as compared to 12,000 hours teaching about reading, writing, and arithmetic. Well, you cannot teach reading, writing, and arithmetic to children who are not physically, emotionally, and psychologically fit.

COMPREHENSIVE HEALTH EDUCATION

When I say comprehensive health education, I am talking about nutrition. I am talking about exercise and activities. I am talking about self-esteem. I am talking about family life education. I am talking about all the things the young people need to be good decisionmakers about their health.

Senator SPECTER. That education is indispensible and maybe I detect a little note of recommendation of education for school boards?

Dr. ELDERS. Sir, let me tell you. I am from Arkansas and when I left, I left 28 schools——

Senator SPECTER. Senator Harkin tells me I am skating on thin ice.

Dr. ELDERS. OK.

Senator SPECTER. I did not notice any ice.

Dr. ELDERS [continuing]. On the waiting list for having school-based clinics. Some school boards do not want to go out there on thin ice and make decisions, they do not want to get any help and any support to do these things. But I am saying that I think our school boards, most of all, want their children to do well. Now our superintendents and principals are saying in Arkansas, the ones that have school-based clinics, that they will never teach in another school that does not have one.

Senator SPECTER. Well, Dr. Elders, you and I talked about this informally before we began. I have heard you talk about this being a matter for school boards and for local decisions, and I agree with that.

Dr. ELDERS. Yes, sir.

Senator SPECTER. That was the answer I gave last night on television. Recently I convened a meeting in Harrisburg and had from central Pennsylvania, which is an area very cautious and very, very thoughtful in not rushing into anything—and we were talking about the matter. I think it has to be a matter of local control.

Dr. ELDERS. Yes, sir.

Senator SPECTER. I do not think it ought to come from Washington, DC, as a matter of dictation.

Dr. ELDERS. Absolutely.

Senator SPECTER. Local boards, parents, teachers are going to have to decide what they want to do by way of dealing with these touchy subjects, and I think part of our job here is to send out the information not only to students, but to teachers and parents as well.

I know you are frank to say and I am frank to say that I do not have the answers. I am getting a fairly good handle on the questions, and the answers we are going to have to come to together.

RELATIONSHIP BETWEEN WELFARE AND TEENAGE PREGNANCY

Let me move to one final subject because you have been very generous with your time, and that is the subject of the relationship between welfare laws, AFDC payments, and teen pregnancy. In your statement you identify that in 1992 an estimated $34 billion was expended on AFDC, Medicaid, and food stamps for families begun by adolescents.

I compliment my colleague, Senator Harkin, for his initiative with Senator Bond—and I am going to be joining them on their legislation because I think it is very, very thoughtful legislation—on the business about having deductions for identified fathers. We have to do more on that. Only 58 percent of teen pregnant women will identify the fathers, and we have to do much more on that. To have mandatory deductions is minimal. You talk about contribution of sperm. There is a lot more to contribute. Those who do the former are not making the contribution. They are doing something else.

But on the subject of the relationship between welfare payments and teenage pregnancy—and there are some very tough ideas out

there about cutting off welfare payments for unwed mothers, teen unwed mothers, and children, which is a little hard to see how you are going to cut it off for children and how you are going to handle that, but there is a furious America out there identified, sick and tired of making welfare payments and seeing the rise of teenage pregnancy. There are those who are saying that the welfare system encourages teenage pregnancy. So, let us tackle that one. That is not an easy one either. What is the relationship between welfare payments and encouraging teenage pregnancy?

Dr. ELDERS. Senator, I do not feel that any thinking young woman would ever have a pregnancy to get welfare. It is too bad that our society would offer our young women no more to want than to get pregnant or to have a baby in order to get a welfare check. I suspect that this may happen, but I feel that the percentage is very, very small. Those will be real problems.

It is my understanding the average length of time that young women spend on welfare is approximately 2 years. So, they are really on and they are off. I think most of them are really trying, but there is a hard core group that we are going to have a very, very difficult time with regardless of what we do. I feel it will be difficult for them to move away from welfare because they have no skills. We have got to be able to find a way to reach them. We have to start early. We have to offer them a skill.

So, I think it is going to be a very difficult problem. We need to offer them an opportunity to get off welfare. Making it better to work than to be on welfare is certainly a useful alternative as most of the young women I know would far rather get up and go to work and get away from the home environment in which they live, a crying baby all day, than to be home. So, that means that we have got to make sure that they get health care. We have to make sure that they have day care, someplace to leave their babies. I think we have to make sure that we teach them how to do something.

THINKING YOUNG WOMEN

Senator SPECTER. Well, Dr. Elders, I agree with your statement that no thinking young woman would have a child as a means of getting on welfare, but I do not know how many thinking young women there are out there.

Dr. ELDERS. Most, Senator.

Senator SPECTER. Well, most. I do not know. Senator Harkin and I and a lot of us here on Capitol Hill are spending a lot of time, and I convened my staff for a lot of brain sessions, Charity Wilson, Bettilou Taylor, Craig Higgins, and Mark Klugheit. We are working on this as so many of us are here, and you just wonder about how thoughtful young women are when they get themselves into teenage pregnancy. I agree with you about the need for day care and the need for jobs and the need for medical care, but I am not sure that we can rely upon the conclusion that thinking young women would not get themselves pregnant to have welfare payments.

Dr. ELDERS. Senator, adolescents do not think very far ahead. They get pregnant but I do not think they went out there planning, first of all, to get pregnant, and, second, to get pregnant to get welfare. I just think you are thinking far deeper than they think.

Senator SPECTER. Well, I am going to think about that. [Laughter.]

Dr. ELDERS. All right.

Senator SPECTER. I am going to think about that because there are a lot of people who are arguing very strenuously that that is the motivating factor and that there ought to be a cutoff of welfare for that reason. We are going to have to give it a lot of thought because there is a lot of popular support for that view. I am not prepared to say who is right and who is wrong.

Dr. Elders, I thank you for coming in. I had the pleasure, as you know, of sitting down with you at some length before your confirmation hearing.

Dr. ELDERS. Yes, sir.

Senator SPECTER. I think that if you are going to make progress, you are going to have to make some waves. I admire what you did before you became Surgeon General. I admire what you are doing as Surgeon General. I will say to you that I have said that to some disagreeing if not hostile audiences in Pennsylvania when we have talked about some of these cutting edge problems and the positions that you have taken. But you have a tremendous background, experience, personal experience, education, and I know that we want to work with you on these very tough issues. So, I thank you.

Dr. ELDERS. Well, thank you, Senator. As I tell people who say, "Well, we wish you a lot of success," I say, "No, I am in a position where you hope I win. I have got to win. The country cannot afford for me to fail."

WELFARE ISSUE

Senator HARKIN. Dr. Elders, I just want to follow up on one thing and that is the welfare issue.

Dr. ELDERS. Yes, sir.

Senator HARKIN. Because we are hearing a lot about it, and of course, a lot of it falls right on this subcommittee because this is where the money comes from. As I said, Senator Bond and I had this welfare proposal in. I just mentioned one part of it.

But like Senator Specter, I hear a lot from people around this country, about young women who get pregnant, have a baby, get on AFDC, have another baby, the AFDC check goes up, have another baby, the AFDC check goes up. People are getting very upset about this. You mentioned $34 billion a year now going out.

Dr. ELDERS. That is right.

Senator HARKIN. A lot of people have suggested to me in different settings that perhaps when a young, unmarried woman has a child and seeks to go on AFDC, which is not a constitutional right, by the way——

Dr. ELDERS. Right.

USE OF NORPLANT

Senator HARKIN [continuing]. That there ought to be an agreement reached with this young woman, that if she wants to go on AFDC, that she should then agree to have Norplant installed, which would give her 5 years of protection from getting pregnant, not forcing her to do it, but just saying, if you want AFDC, then

you agree to Norplant. Some people are saying that. Then if they do not agree to that, then they do not get AFDC. How would that work?

Dr. ELDERS. Well, Senator, I as an individual would be very much opposed to something like that. I think that it is important to really educate young women. I feel if we educate them, make them aware that Norplant is out there, and make it available to them, a very large percent—in fact, up to 90 percent of young women—would probably choose to use Norplant. But if they did not choose, I feel that if they seek other options of trying to prevent a pregnancy they should have that option. I do not feel that making them go on Norplant should be a condition of AFDC.

Senator HARKIN. So, you are saying that perhaps the approach ought to be one of providing Norplant to young women, providing them the education, what it will do for them, the protection it will give them, but not making that a condition precedent to whether or not they receive AFDC.

Dr. ELDERS. Yes, sir.

Senator HARKIN. Well, I will have to think about that.

Dr. ELDERS. Today in our society Norplant is really not available for poor women.

Senator HARKIN. Because it is too expensive?

Dr. ELDERS. Because it is too expensive. Family planning is available for 2 months after they have had a baby. They can get Norplant within 2 months, because they are still eligible for Medicaid.

I really feel very strongly that when we expanded our Medicaid Program for pregnant women up to 133 percent of the Federal poverty level, we should have expanded it to include reproductive health for that same income level. At least we should make other reproductive health services available and then we could really prevent a lot of the pregnancies that we now have.

Senator HARKIN. You are saying that a young woman—we are talking about teenage pregnancies here.

Dr. ELDERS. Yes.

Senator HARKIN. Let us say a young teenager has a child. She is unmarried, goes on AFDC, that under Medicaid she cannot get Norplant?

Dr. ELDERS. If she is Medicaid eligible only because of her pregnancy and does not get family planning within 2 months—she may no longer be eligible for Medicaid.

Senator HARKIN. I did not understand that.

Dr. ELDERS. I do not think most people have understood that, but we as health officers were trying to get that changed because we had many young women who really wanted Medicaid.

In a small State like Arkansas, we had a waiting list of over 2,000 young women who wanted Norplant, but we did not have the money to purchase it. Finally, we convinced our legislators to give us the money to purchase some Norplant. So, we have really been working very hard on this issue. It may not be related to our education program but it may be one of the reasons we are seeing a decrease in pregnancy in Arkansas and I think that that is really critical.

COST OF NORPLANT

You see, Senator, it is more than $365 for the kit. So, a young person or a poor family needs to have $500 to cover both the kit and insertion. It is just not available for poor women.

Senator HARKIN. It costs $500. I did not realize it was that expensive; $500.

Dr. ELDERS. The kit is $365 and most doctors will——

Senator HARKIN. Yes; $365 and about $150 to put it in.

Dr. ELDERS. To put it in. Our family planning programs, as you know, have had only minuscule increases—an average of $15 per poor woman.

Senator HARKIN. Let me get this straight. Now, Medicaid will cover Norplant but only for that 2-month period of time.

Dr. ELDERS. Let us say if you are poor and not working and just on AFDC, you are on Medicaid.

Senator HARKIN. Right.

Dr. ELDERS. So, now Medicaid will cover it.

Senator HARKIN. It will cover it.

Dr. ELDERS. It will cover it.

But let us say that if you are borderline——

Senator HARKIN. I understand.

Dr. ELDERS [continuing]. Working at McDonald's, you are only eligible for Medicaid for 2 months after your delivery.

Senator HARKIN. Well, maybe we should expand our thinking on this. We make contraceptives available.

Dr. ELDERS. Yes, sir.

Senator HARKIN. I think you have advocated that and others have.

Dr. ELDERS. Yes, sir.

AVAILABILITY OF NORPLANT

Senator HARKIN. Perhaps we should back this up and make even Norplant available, not just to someone who has had a child, but even before that.

Dr. ELDERS. Senator, that would be a real help—you would save this Government more money than any other single thing that you would do. You would reduce low birth weight, you would reduce the number of women on AFDC, you would reduce the number of unplanned, unwanted children, and you would make all contraceptives available to young women—it would be hard for a young person to ask their parents for $500 for Norplant.

Senator HARKIN. Staff tells me that family planning facilities could offer this if they had the money to do so. Is that right?

Dr. ELDERS. Yes; that is right, but they really do not have the money to do so. They get their pills very cheap, but they do not have the money for Depo Provera or Norplant. Some offer it just very sparsely.

Senator HARKIN. I am also going to take a look to see whether or not if the Government purchases more Norplant, I would think that the price would have to come down on it.

Dr. ELDERS. Yes, sir; we certainly tried that. They have held hearings on it and we have talked about it, but it is still a real problem.

CLOSING REMARKS

Senator HARKIN. Senator Specter, do you have any follow-up at all?

Senator SPECTER. Mr. Chairman, I just will submit some questions in writing. You have been here quite a while, but there are a great many important subjects which we have prepared, staff has prepared, questions on which I would like to submit for answers in writing.

Dr. ELDERS. Yes, sir; I would be happy to.

Senator SPECTER. The only final question that I would have, I read in Dr. Koop's book that he was both a general and an admiral. I became a little confused by that. There was a fair amount of other material in Dr. Koop's book that confused me too. But which are you? A general or an admiral? You are the Surgeon General, but you are——

Dr. ELDERS. I am the Surgeon General, but I am an admiral by rank. I am a vice admiral.

Senator HARKIN. As an old Navy man I can tell you those are admiral stripes not general stripes. [Laughter.]

Senator SPECTER. Well, as an old Englishman, how about that Surgeon General General? [Laughter.]

Thank you very much.

Senator HARKIN. And thank you for your leadership. I just want to say publicly that I appreciate what you are doing. As Senator Specter said, someone once said the turtle makes progress only when he sticks his head out or someone else said the biggest ships always make the biggest waves, but they get to the port first. You are making waves. You are making good waves because you are challenging us to think beyond our own narrow confines and to really take a hard look at just what is happening in our society. Sometimes we need that cold splash of water in the face to wake up to reality, and I thank you for that very much. Keep on doing your good work.

Dr. ELDERS. Thank you very much, Senators.

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

Senator HARKIN. Thank you, Dr. Elders. There will be some additional questions which will be submitted for your response in the record.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

TEENAGE PREGNANCY AND CHILDBEARING IN ARKANSAS

Question. Dr. Elders, would you please describe how you responded to teenage pregnancy and childbearing when you were the chief public health officer in Arkansas?

Answer. The majority of my efforts focused on educating the public about the problem. I spent a great deal of time speaking to legislators, civic groups, churches, school boards and other state and local groups about the tremendous teenage pregnancy problem in Arkansas. A statewide media campaign was developed and aired on the NBC television affiliate. Billboards were erected throughout the state drawing attention to the problem. We manned a toll-free teen pregnancy hotline to provide health information to callers and direct them to health units for services. Public health clinics were encouraged and after-hours clinics expanded. In several areas programs for adolescent males were initiated.

My main strategies in preventing teenage pregnancy are closely linked with providing adequate health care for adolescents. Under my leadership, the Arkansas Department of Health opened 26 school-based clinics to provide preventive health services to school-aged children. The schools selected the services to be offered, and we soon discovered that in those schools with clinics, the health education curriculum became more comprehensive and began to address the issues and concerns of the students on a daily basis, not just a few thirty minute lectures on selected topics. There was a waiting list of 21 more schools seeking clinics when I left the state. I feel there would have been more had a funding source been secured for school-based health clinics.

I also authorized all the local health units to do birth control counseling and provide patients with birth control at their initial visit, rather than waiting until after their physical examination had been performed.

Question. What lessons did you learn - successes and failures -while you were working at the State level that have formed the policies that you are proposing today as Surgeon General? In particular, I understand that the teen pregnancy rate in Arkansas has been reduced. Can you tell us what contributed to that reduction in the teen pregnancy rate?

Answer. I believe the teen pregnancy rate has been reduced in Arkansas because of the comprehensive approach developed in the state to address the problem. I convinced everyone I could get to listen that it required commitment from the full community to reduce the number of teen births. The health department distributing condoms will not get the job done. New partnerships must be formed. Leaders in the local community must work with their schools and their young people to provide them hope for their future through educational opportunities and jobs. Churches and civic groups must activate to teach young people how to be responsible for their lives. Young people must be provided with accurate information so they can make informed choices in their lives.

Although I believe abstinence-based programs provide an appropriate tool in preventing the early onset of sexual activity in young adolescents, I also know that there comes a time when you must offer full and complete contraceptive information to teenagers who have chosen to become sexually active.

My failure would be my inability to secure a funding stream to support both school-based health clinics and comprehensive health education programs for Arkansas. Since becoming Surgeon General, my staff has worked closely on the health care reform initiatives and other legislative proposals which would establish federal grants for these programs.

ADOLESCENT PREGNANCY AND HEALTH CARE REFORM

Question. How are your policies to address adolescent pregnancy incorporated into health care reform and welfare reform?

Answer. The President's health reform proposal contains two key components that would provide authority for the development of comprehensive, sequential, age-appropriate health education programs in the schools and school-based health services.

The Administration's welfare reform proposal also has several important components targeted at preventing adolescent pregnancy--a national campaign to bring together schools, communities, families and churches in preventing adolescent pregnancy, a grant program to develop ongoing and innovative pregnancy prevention programs, and broader initiatives to change the circumstances in which high-risk young people live.

ADOLESCENT FAMILY LIFE PROGRAM

Question. Dr. Elders, why has the Administration proposed to cease funding the Adolescent Family Life program?

Answer. The President's Fiscal Year 1995 budget proposed shifting the $6.8 million in AFL program funds to support a new Office of Adolescent Health (OAH), previously authorized by Congress but never funded. However, Congressional action in both Houses on the FY 1995 appropriations bill for the Department directs that funding for AFL be continued.

In light of increasing rates of morbidity and mortality among adolescents and the interrelatedness of behavioral factors which increase risks to adolescents' health, it is important that we place more emphasis on this population. We need to develop and evaluate newer, more comprehensive approaches to the health problems facing youth, including adolescent pregnancy prevention, than are possible with current programs.

OFFICE OF ADOLESCENT HEALTH

Question. What do you plan to accomplish in terms of teen pregnancy in the Office of Adolescent Health that was not accomplished by AFL?

Answer. While adolescent pregnancy prevention would continue to be a priority for the OAH, the focus of the Office of Adolescent Health will be broader than pregnancy prevention. Research has shown that health risk behaviors tend to cluster together; adolescents at risk of early sexual involvement and pregnancy are also likely to have used substances such as drugs and alcohol, are more likely to smoke, and are less likely to be appropriately supervised during out-of-school hours.

Research also shows that although adolescents are usually regarded as a healthy population, an estimated one in five has a serious health problem. In addition, adolescents often face substantial barriers in accessing health care. Information, income/insurance, legal, transportation, and social psychological issues can all play a role in discouraging or preventing adolescents from seeking necessary services.

Our Adolescent Health initiative will focus on health issues specific to adolescents--disease prevention and health promotion, preventive services, and information and education--to better document service and delivery needs, develop policy, and coordinate activities with other agencies, both in and outside of government, to improve adolescent health.

DELAY OF ADOLESCENT SEXUAL ACTIVITY

Question. One component of the Adolescent Family Life program has been to delay the onset of adolescent sexual activity. Would the Office of Adolescent Heath also focus on programs which promote abstinence?

Answer. Our focus on adolescent health will certainly include abstinence as part of its strategy for improving the health of adolescents and reducing the risks they face. Delaying or preventing early adolescent sexual activity prevents pregnancy and the transmission of sexually transmitted diseases, including HIV infection. However, abstinence messages do not work for everyone, and we therefore, need a more comprehensive approach which presents abstinence within a broader program that provides accurate and complete sexuality education, information on contraception and avoidance of sexually transmitted disease, and access to reproductive health services, including contraception for those who are sexually active.

GOAL OF SURGEON GENERAL

Question. Dr. Elders, prior to your confirmation, you stated that your top goal as U.S. Surgeon General would be to "ensure that every child born in America is a planned, wanted child". To achieve this goal, you planned to focus on age-appropriate health education and improved access to federally funded reproductive services. Since becoming Surgeon General what steps have you taken to ensure that this goal is achieved?

Answer. As you know, I have been and continue to be a fervent supporter of comprehensive school health education and have worked diligently to ensure inclusion of the school-related health services and comprehensive health education provisions contained in health care reform. Whatever the ultimate outcome of the health care reform debate, I believe these particular provisions are essential to improving the health of American youth and helping in our efforts to prevent teenage pregnancy, and I will continue to advocate for passage of this legislation whether as part of health care reform or as a separate proposal.

I also support family planning services as a key element in dealing with adolescent pregnancy prevention. Among other things, the Title X family planning program has developed and put into place new program priorities, emphasizing outreach to hard-to-serve populations such as substance abusers and homeless persons, STD and HIV prevention, services to adolescents and comprehensiveness of reproductive health services. Recently a 5 year, $2 million grant was awarded to the Alan Guttmacher Institute to assess data on the need for family planning services, the population being served by the family planning program and to develop a profile of the services clients are receiving.

AGE-APPROPRIATE HEALTH EDUCATION

Question. Would you give us some examples of what you consider age-appropriate health education?

Answer. Ideally, comprehensive health education programs provide basic information on health promotion and disease and risk avoidance in the earliest grades, and supplement this information with more detailed and complex concepts as children's cognitive skills and need-to-know increase and develop. Such programs would emphasize basic understanding of growth and development, family life, nutrition, safety, first aid, injury and violence prevention in the earliest grades, and provide more comprehensive treatment of these topics as the child's capacity for understanding increases, while adding environmental health, tobacco and other substance

abuse, disease prevention and control, mental and emotional health and human sexuality as needed and appropriate.

Question. As you know, Dr. Elders, the Federal government does not dictate curriculum to State and local education agencies. What role do you see for the Federal government in developing comprehensive school health education programs?

Answer. School health education programs are properly the province of State and local education agencies. The Federal role in this area is to assist communities to develop and adopt the health education programs which they decide that they need and want. Our school health education proposal that was part of the Health Care Reform plan does not mandate anything; it is a grant program to which communities or school systems can apply if they want the kind of help which this program can provide. I know well enough that programs which do not have the support of the school system and of the parents of the students are unlikely to be successful.

PREVENTION IN THE NATION'S SCHOOLS

Question. The Centers for Disease Control and the Department of Education operate programs to help the Nation's schools implement comprehensive school health programs. How could the prevention of teen pregnancies be addressed as part of these efforts?

Answer. Adolescent pregnancy prevention efforts would be an important component of any comprehensive school health program. As I have already stated, delaying early adolescent sexual activity is the best way to prevent pregnancy and the transmission of sexually transmitted disease and we should encourage programs that promote abstinence. However, not all adolescents are, or will remain, abstinent and we must also provide them with accurate information about sexuality and contraceptives. Programs such as Postponing Sexual Involvement and Reducing the Risk provide both abstinence and contraceptive education and have shown promising results in delaying sexual activity and improving contraceptive use when adolescents do become sexually active.

Question. When you were Chief Public Health Officer in Arkansas, public schools in Arkansas had a variety of health education programs. How does a school board or community decide what type of program is appropriate for its students?

Answer. Communities need to have communication about the best ways to educate their children. This is especially true when it comes to health and sexuality education. A school system which unilaterally initiates a health education program that is offensive to the parents and the community will learn this lesson very quickly. It is much better to have discussions and get parents' support first rather than having to try to convince them of the wisdom of an approach after they raise objections to it. Most parents, when given the opportunity to consider and have input into a health education curriculum, end up taking very responsible and helpful positions.

SCHOOL-BASED CLINIC SERVICES

Question. Some people maintain that school-based clinics are an important element in strategies to prevent adolescent pregnancies. At this time, however, less than 20 percent of school-based clinics reportedly provide contraceptives, and many proposals to offer contraceptives are traditionally opposed by some parents and community groups. Others observe that school-based health clinics are closed on weekends and during vacations, times when teens are most likely to need advice or contraceptives. While schools are the place most adolescents can be reached, those teens at greatest risk of pregnancy are more likely to be dropouts or have truancy problems.

BEST COPY AVAILABLE

In your opinion are school based health clinics an essential component of an effective plan to reduce teen pregnancy? How do you build community and parental support for such a controversial service?

Answer. I believe that both comprehensive health education and school health services are a vital part of efforts to reduce adolescent pregnancy. Using schools is a highly efficient way to reach the majority of young people in the United States. School-based and school-linked centers provide a unique opportunity to provide health services to youth and to realize potential future cost savings. Concern about provision of controversial services such as contraception has focused much attention on school-based health services; what has been missed in the confusion is that other important services, such as mental health and depression counseling, suicide prevention, and substance abuse screening, referral and treatment are also important parts of the services provided in these settings.

I believe that public education about the vital role school health services can play in promoting healthy behaviors and in preventing problems like adolescent pregnancy will go a long way in building community and parental support. Schools are the one consistent institution where children and youth congregate and spend most of their day. Placing services at or near schools makes them easily accessible to students, allowing easy followup with minimal disruption in the school environment. In addition, since schools are usually at the center of most communities, they can be a supportive environment for many health-related activities aimed at youth, their families and the community at large, such as the reinforcement of positive health habits through health promotion and disease prevention activities.

Question. Do you see any pitfalls to school-based clinics offering family planning services and distribution of contraceptives?

Answer. I believe comprehensive school health education programs can provide real opportunities to both encourage abstinence and provide the necessary information to teach young people to act responsibly if and when they do decide to become sexually active. School health services are logical partners to comprehensive health education programs in that they can increase access to primary and preventive health care services -- including family planning counseling and contraceptive services. Because family planning services in schools can be and have been controversial in some communities, most school health care centers to do not provide such services on-site. While I believe such services are very important, decisions to include these services should be made by local communities.

FATHER'S NAME ON BIRTH CERTIFICATES

Question. Dr. Elders, statistics indicate that only 58 percent of teen moms report the father's name on birth certificates. Why to you think teens are reluctant to name the fathers of their children?

Answer. This is a perplexing question. In some cases, a pregnant adolescent's failure to report the name of the father may reflect her assessment that he will retaliate in some way or simply deny his responsibility. In other cases, the young woman may be reluctant to name the father if the pregnancy was the result of a forced sexual relationship or incest. The young woman may be unaware that there are laws to ensure that males share financial responsibility for child support, or they may have little confidence in the ability of society to enforce these laws.

In other cases, the pregnant adolescent may be making the judgment that the male is unlikely to be a good father and be reluctant to confer potential paternal rights by naming him. This may particularly be the case if the sexual contact was casual and the pregnant girl has little or no interest in continuing the relationship with the male involved.

Question. Over 55 percent of the men named as fathers to teen moms are over 20 years old. As we explore ways to reform our welfare system, I would be interested in knowing your thoughts on how we can require men to take parental responsibility for their children?

Answer. The President's welfare reform proposal directly addresses this issue by incorporating provisions that promote parental responsibility and ensuring that fathers, as well as mothers, contribute to their children's support.

Included in the proposed plan are: universal paternity establishment; regular child support awards updating; wage-withholding and suspension of professional, occupational and drivers' licenses to enforce compliance in paying child support; a national child support clearinghouse to track child support payments across State lines; and several State options and initiatives to encourage responsibility.

AVAILABILITY OF DATA ABOUT TEEN PREGNANCY

Question. Recent reports from CDC indicated that important information about teen pregnancies is not available for all States. Does the absence of this information prose a problem to states in targeting programs and resources to communities?

Answer. The limitations of interpreting data on adolescent pregnancy are related in part to the lack of a coordinated national pregnancy surveillance system. The data used to monitor adolescent pregnancy are obtained by several data collection systems that have different methodologies. In addition, the frequency of data collection varies greatly among the systems; some systems collect data annually, whereas other collect data periodically.

Adolescent pregnancy is a significant and complex public health problem. Timely data on adolescent pregnancy--both at the national and state level--is crucial for monitoring trends and assessing the effects of efforts to reduce unintended pregnancy. By monitoring all components of teenage pregnancy--data on live births, abortions, miscarriages and stillbirths, and sexual experience--states can collect data that are critical to monitoring and evaluating family planning programs, identifying and assisting adolescents at high risk, and implementing additional activities to reduce teenage pregnancy.

Question. What can be done to help those states that lack information about teen pregnancies and the effectiveness of programs designed to prevent teen pregnancies?

Answer. The number of pregnancies occurring during a specific period is obtained by summing the number of births, abortions and fetal losses. When these data are available by demographic characteristics such as age and race, pregnancies and pregnancy rates can be calculated for specific population subgroups.

The U.S. Vital Statistics System provides detailed information on births at several geographic levels, including State level, and fetal losses are usually obtained by estimate. Abortion data are collected in each State, but not all States collect these data by age. Therefore, not all States can calculate numbers or rates of adolescent pregnancies. A uniform data collection system for abortions, similar to what we already have for births, would be the simplest way to remedy this problem. Alternatively, estimation procedures could be developed and used.

NONDEPARTMENTAL WITNESSES

STATEMENT OF CAROL MACHAEL, EXECUTIVE DIRECTOR, WOMEN'S HEALTH SERVICES, CLINTON, IA

Senator HARKIN. Next, we will hear from Ms. Carol Machael, Dr. Marion Howard, Ms. Lakita Garth, and Mr. Darrell Green.

I have to apologize. Down the hall and up one flight of stairs the Labor and Health Committee, of which I am a member, is marking up our health care reform bill, and I had to announce to them that I had to leave to come down here on an issue that is very important in terms of health care reform, which is teenage pregnancy. I now have to apologize. I have to go back upstairs because Senator Kennedy is holding some time for me to offer an amendment on, believe it or not, school-based health programs. So, I have to juggle this time. So, I do apologize to you.

I would just want to welcome Mrs. Carol Machael who has been the executive director of Women's Health Services in Clinton, IA since 1984. The agency provides services to over 4,000 women annually, including prenatal care for approximately 350. Under Ms. Machael's leadership, the Women's Health Service spearheaded a parenting education and support services directed at the teen or high-risk mother and also established teen health centers in two middle schools and two high schools. I just wanted to mention that for the record.

I will turn over the introductions of the other panelists to Senator Specter. Again, I apologize deeply. I will read your testimonies and if I can get my amendment offered and get back here in a hurry, I will be back before you finish. I will now turn it over to Senator Specter for the further introductions and for the testimony, and I thank you very much.

Senator SPECTER. Thank you, Mr. Chairman. You are very optimistic about getting your amendment adopted that fast.

Senator HARKIN. I will try.

Senator SPECTER [presiding]. Dr. Marion Howard is clinical director, Teen Services Program, Grady Health System in Atlanta, GA. She is also the director of the Center for Adolescent Reproductive Health and a professor of gynecology and obstetrics at Emory University of Medicine. In 1985, Dr. Howard established a program aimed at teens, aged 12 to 14, entitled: "Education Now, Babies Later" to help them learn and practice the skills necessary to postpone sexual activity.

Ms. Lakita Garth is on the Board of Directors of the Athletes for Abstinence Program, which is part of the A.C. Green Youth Foundation. Ms. Garth spends a great deal of her time speaking to junior and senior high school students about abstinence. A gifted performer, she is also an active member of Women in Network, an organization committed to establishing effective Christian leadership in America.

Mr. Darrell Green is an all-pro cornerback of the Washington Redskins, a five time pro bowler, and has won the NFL's fastest man competition in 1986, 1988, 1989, and 1991. He founded the Darrell Green Youth Life Foundation which provides financial and moral support for D.C. youth and their families. He serves as vice president of the Fellowship of Christian Athletes and devotes time to Big Brothers of America.

It is a pleasure to have all of you here. I have not had the pleasure of meeting any of you before, but I have seen a great deal of Mr. Green. I am surprised. He looked much bigger when he decimated the Eagles than he does today. [Laughter.]

So, we welcome all of you here and we will start with you. We have timers. Your full statements will be included in the record, and we ask you to summarize your oral presentation to the extent you can. Ms. Machael, we welcome you and ask you to proceed.

SUMMARY STATEMENT OF CAROL MACHAEL

Ms. MACHAEL. Thank you. My name is Carol Machael. I have been executive director of Women's Health Services in Clinton, IA for the past 20 years. Women's Health Services is a private, not-for-profit agency receiving title X family planning funds, title IV maternal and child health funds, and our single largest source of income is patient fees and third party reimbursements.

Our entire area was hit hard by the farm crisis of the early 1980's, and despite the upswing in the Midwest in the past few years, the area has never fully recovered. Salaries have declined. Manufacturing business has been lost and the new jobs tend to pay poorly and lack benefits.

Teen pregnancy rates are increasing. The rate for Clinton County is 11.8 against the statewide average of 10.2. Teens are becoming pregnant at earlier ages.

Many teens are choosing pregnancy or are declining action to prevent it. Daily sexually active teens access our family planning centers for pregnancy tests and refuse to leave with condoms or schedule exams for other birth control methods. We believe that teen pregnancy is not totally a failure of family planning.

Our efforts to provide services directed toward this problem include providing a social worker who sees teens at teen health centers in the schools, children and their parents at well child clinics. She sees all our pregnant patients at least three times during the pregnancy and all family planning patients who are 15 or younger.

We felt that very young teens using our services were very often in situations we considered harmful and abusive with men aged 18 to 30 rather than their peers.

Our staff provides nonjudgmental counseling that says we are not telling you what to do, but we are telling you that teens who have babies live in poverty, have a hard time finishing their education, and find that their boyfriends do not often stay around.

We also felt that young males needed to hear some of the same messages. Our male health educator presents the message that males can and do communicate about sex without embarrassment. He discusses condom use, abstinence, and that males can and should be a partner in issues of contraception and planning pregnancy.

One thing is clear. Parents have the whole life of the child to teach responsibility. Health educators are expected to teach it in a 45-minute class period. When the message fails, it is blamed more often on poor education than on poor parenting.

Our concern is that with the onset of managed health care, family planning agencies will no longer have the funding to provide a valuable community service that does not pay its way.

We are proud of our Young Moms program based on the MELD program from Minnesota where parenting teens attend groups facilitated by women who were once teen parents themselves. Its goals are to assist the teen in continuing her education, reduce the incidence of child abuse, and eliminate second pregnancies during the teenage years. The Ford Foundation suggested that the rate of second teen pregnancy is somewhere between 25 and 50 percent. However, for those teens participating in our Young Moms Program, the repeat pregnancy rate has been 2 percent.

These teens give to their community by speaking to classes of younger students about teen pregnancy and volunteering within the community.

Other programs critical to the prevention of teen pregnancy and the fostering of independence of teen parents are the title X family planning program, full and comprehensive title V maternal and child health services, and health care services in the schools. With all of the programs available, we must recognize that no amount of money can meet the needs of children who have not been parented properly or parented at all. It is of critical importance, we believe, to assist young parents develop those skills that will make a difference for the next generation.

There is a strong feeling that family dysfunction is at the heart of teen pregnancy issues: families where limits are not set, where parents are absent, I suppose where the TV is on all the time, or alcoholism and abuse is present. A contributing factor is also the hopelessness of a community where jobs pay poorly and benefits are nonexistent. Disadvantaged teens do not have the motivation to delay parenthood or the strength to keep them from becoming victims.

Teen fathers seem to be encouraged by the system to be unreliable and absent. Often the mother receives greater financial benefits when he is out of the picture than when he is in.

PREPARED STATEMENT

We believe that programs which assist young parents, not by giving to them or doing for them, but helping them to develop the capacity to cope, to plan for the next few years rather than the next few hours, to feel successful through helping others, and to learn how to gather information and make decisions are at least a part of the answer to our problems. Only a solution like this foster self-sufficiency, independence and pride in our young people and our young families.

Thank you.

Senator SPECTER. Thank you very much, Ms. Machael. We will have some questions but at the conclusion of the entire panel.

[The statement follows:]

STATEMENT OF CAROL MACHAEL

My name is Carol Machael. I live in Clinton, Iowa and have been executive director of Women's Health Services for the past 20 years. Women's Health Services is a private, not-for-profit agency serving Clinton, Jackson and Cedar counties in Iowa. We receive Title X family planning funds, Title V for our Maternal Health and Well Child Programs, and have numerous other state and local funding sources (such as United Way) to support our programs. Our single largest source of income is patient fees and 3rd party reimbursements, including Medicaid.

The largest city in this area is Clinton, on the Mississippi River, bordered by farmland--population 29,000 and falling. The entire area was hit hard by the farm crisis of the early 80's, and despite the upswing in the Midwest in the last few years, the area has never fully recovered. Salaries have declined, manufacturing business has been lost, and the new jobs tend to pay poorly and lack benefits.

THE PROBLEMS:

Teen pregnancy rates are increasing. The teen pregnancy rate for Clinton County is 11.8, against a statewide average of 10.2 for 1992 (the most recent year for which statistics are available).

Teen are becoming pregnant at earlier ages.

Many teens are choosing pregnancy--or are declining actions to prevent it. Daily, sexually active teens access our family planning centers for pregnancy tests, and refuse to leave with condoms or schedule exams for other birth control methods, saying, "If it happens, it's OK". Staff are frustrated; but no amount of counseling seems to make a difference. Teen pregnancy is not a failure of family planning; it is a failure of something more elemental in our society.

In the interest of preventing unintended pregnancy and its accompanying social problems, Women's Health Services has tried many things:

1. SOCIAL WORKER

Our social worker sees teens at the teen health centers in the schools, children and their parents at the well child clinics; she sees all our pregnant patients at least 3 times during the pregnancy, and all family planning patients who are 15 or younger. We felt that very young teens (under age 16) using our services were very often in situations we considered harmful and abusive--with men aged 18-30, rather than their peers. We have required all teens 15 and younger to see the social worker within one month of receiving services.

Our staff provides nonjudgmental counseling that says, "We aren't telling you what to do, but we are telling you that

teens who have babies live in poverty, have a hard time finishing their education, and find that their boyfriends often do not stay around to pay child support".

2. HEALTH EDUCATION DESIGNED FOR MALES.

We felt that young males needed to hear some of the messages. Males and their needs have been addressed too little of the time. With funds allocated by the state for pregnancy prevention, we hired a male health educator, who works as a team with our female health educator, making more than 750 presentations in more than 30 schools, from elementary through college, each year.

The message presented by our male health educator is that males can and do communicate about sex without embarrassment, that abstinence is the best method of preventing pregnancy and STDs; he discusses condom use, sexual responsibility issues, and that males can and should be a partner in issues of contraception and planning pregnancy; he shows males that they should be knowledgeable about and a partner in contraception and pregnancy planning--sharing the cost of contraception, accompanying the girlfriend to the clinic for services, etc.

One issue is very clear--parents have the whole life of the child--18 years--to teach responsibility--health educators are expected to teach it in a 45 minute class period. When the message fails, it is blamed more often on poor education than on poor parenting!

You should be aware that there is no funding source for most health educators hired by family planning agencies to provide these important messages. Our concern is that with the onset of managed health care, family planning agencies will no longer have the funding to provide a community service that does not pay its way. If Women's Health Services were in serious financial trouble, our health educators and our Young Moms programs would be the first to go.

3. TEEN HEALTH CENTERS IN SCHOOLS

Staff from Women's Health Services and 5 other community agencies provide counseling services in the schools. We have a nurse practitioner providing prenatal care in the high school, but unfortunately neither family planning medical services nor contraceptive supplies, such as condoms, are provided in Iowa schools. The trend to locate community services on school sites is flourishing, however.

4. PROGRAM FOR PARENTING TEENS

We are proud of our Young Moms' program, based on the (MELD) Minnesota Early Learning Design program--where pregnant and parenting teens attend groups facilitated by women who were once teen parents themselves. This program is an inexpensive one, funded in part by the Iowa Chapter of the National Committee to Prevent Child Abuse, Target Stores, and the Iowa Department of Human Services.

Program goals are: 1) to assist the teen in continuing her education, at least through high school; 2) to reduce the incidence of child abuse; and 3) to eliminate second pregnancies during the teenage years. A number of years ago the Ford Foundation suggested that the rate of 2nd teen pregnancy is somewhere between 25-50%. Our informal analysis would corroborate that. However, for those teens participating in our Young Moms program, the repeat pregnancy rate has been 2%. Our similar programs seem to have the same success rate.

The groups meet weekly, 10-15 teen mothers in each group. Teens are invited to bring their children and childcare is provided. One of these groups is part of the curriculum at the alternative high school; others are located at another high school and a church.

Programs designed to enhance the self-esteem of these teen moms have been particularly successful. Panels of teen mothers talking to junior high classes about their experience with teen parenthood has multiple benefits. One teacher said their presentation was the most powerful message that could be given to her class to delay sex or use contraception. Being an "expert" enhances a teen mother's self-esteem, as well as assists in development of social and speaking skills.

Giving back to the community by volunteerism has helped teen mothers as well--this is their opportunity to feel like contributing citizens. Some babysit in Women's Health Services' daycare area, others assist a local school with their extra curricular activities, and still others are volunteering to help in development of a new program in the community.

5. HOME VISITATION FOR NEW PARENTS

Partners in Parenting, a home visitation program for all new parents in the rural Jackson County, is a means of encouraging development of those skills necessary to be an effective and nurturing parent. This is a prevention program which pairs trained volunteers with inexperienced or new parents considered at-risk, to provide support and assistance.

6. FAMILY PLANNING PROGRAM:

Family planning is not new or innovative, but it is critical to prevention of teen pregnancy. We have three clinic sites in two counties because we are concerned that young teens who cannot drive often have difficulty accessing desired services. In the more urban areas, access is not a problem.

7. TITLE V MATERNAL AND CHILD HEALTH SERVICES:

There is a requirement of the Iowa Department of Public Health that Title V maternal health and well child services must assure that patients see a dental hygienist, WIC nutritionist, and social worker in addition to medical staff and educators. Although this relates only indirectly to teen pregnancy, as about 30% of our patients are teens, we do strongly believe that comprehensive,

multi-disciplinary services should be available in all health care settings to assist young people in making informed decisions about their health care and their lives.

According to a study by Brindis and Jeremy, 1988, key factors in successful pregnancy prevention programs are:

1) early intervention
2) accessibility and acceptability
3) continuity
4) targeting services according to age, gender, and socio-economic background
5) institutionalization and integration into existing services (schools, etc)

With all of the programs available, we must recognize that no amount of money can meet the needs of children who haven't been parented properly or parented at all. It is of critical importance, we believe, to assist young parents develop those skills that will make a difference for the next generations.

The bi-county area of Clinton and Jackson County, in a progressive and innovative collaboration to determine how best to spend the available dollars has felt that prevention is more cost-effective than trying to fund programs once the problem has occurred. They have begun to target discretionary funds at programs that can make a difference early.

There is a strong feeling that family dysfunction is at the heart of the teen pregnancy issue--families where limits are not set, where parents are absent--where alcoholism and abuse is present-- and a strong contributing factor is the hopelessness of a community where jobs pay poorly and benefits are non-existent. Disadvantaged teens do not have the motivation to delay parenthood or the strength to keep them from becoming victims.

Teen fathers seem to be encouraged, by the system, to be unreliable and absent. Often, the mother receives greater financial benefits when he is out of the picture than when he is in.

Teens females have incentives, institutionalized and otherwise, to become pregnant when they are discouraged:
1) the opportunity to leave a home which is disruptive and set up their own household with the help of the welfare system, and
2) the misguided expectation that a child will supply the emotional needs experienced by the teen. Teens want to be loved, and to feel a part of something. Listen to the words of a young 15 year old from a rural area who wrote to our social worker:

"...My mom works from 8-4:30 and she is also going to school. She usually is not home till about 10:00 or 10:30. And my dad usually don't talk--well actually he don't like to hear my personal problems. So I feel really bad about myself. My ex-boyfriend...was making jokes about me..last night..telling (friends) I was easy. And all night guys were grabbing me and making advances toward me. I felt really low. ...I hope I feel better but I doubt I will cause I still feel really really lonely. I'll be glad when this is all over."

It will be no surprise if this young teen is pregnant within the year.

My own philosophy in bringing up my children was to hug them daily--if they had that physical contact from me--their mother--perhaps they would not be starved for that contact from someone else.

We believe that programs which assist young parents--not by giving to them or doing for them--but helping them to develop the capacity to cope, to plan the next few years rather than the next few hours, to feel successful through helping others, and to learn how to gather information and make decisions--are at least part of the answer to our problems. Only a solution like this will foster self-sufficiency, independence, and pride in our young people and our young families.

Iowa is in the early stages of a welfare reform program with promise. It offers incentives for saving money for education or housing, and does not penalize a parent for working, but rather, encourages him or her to work.

Those of us working in the health care and human service fields are hopeful that a collaborative integration of community effort with state and federal programs will be encouraged so that programs can be fine-tuned to meet specific needs of the community for the good of all citizens.

STATEMENT OF MARION HOWARD, Ph.D., DIRECTOR, TEEN SERVICES PROGRAM, GRADY MEMORIAL HOSPITAL, ATLANTA, GA

Senator SPECTER. Dr. Howard, the floor is yours.

Dr. HOWARD. I direct a family planning clinic at Grady Memorial Hospital for very young teenagers. We see 1,500 sexually active adolescents in that program each year.

What has happened is the age of fertility, that is, when young people can begin to bear children, has been dropping 3 months every 10 years for the last 100 years, so half of all girls now become fertile before the age of 12. It is roughly 1 year later for boys. This means that they actually can bear a child before they can clearly see the consequences of their actions on their futures and

before they can really take full responsibility for the consequences of our actions.

When I thought about what our society does, we do a lot for the young person who does become sexually involved. In my family planning clinic, I can give them all kinds of services. I can treat their sexually transmitted diseases, give them counseling, provide meaningful ways of preventing pregnancy or STD's. If a young person becomes pregnant, we can give them prenatal care. We can give them social work services. As you mentioned, they can get welfare. It does not mean that much, but they can get it.

But we do not do anything for the young person who does not want to become sexually involved. We do not even say good job. There is no institutional support in any way for young people who have decided to remain abstinent.

So, one of the things that is clear for me is that because of what you said about society, kinds are caught between two bumper stickers. One says just do it and one says just say no. Without adult guidance, how are they to manage all these very explicit messages about sexuality in our society?

So, we have come to the conclusion that our society does have strong values and we can transmit those values to young people when we do it in age and developmentally appropriate ways.

So, at Grady Hospital what we have developed is a program we call postponing sexual involvement. It starts with a given value: you ought not to become sexually involved at your age. Everything in the program is designed to support that value.

We actually train 60 11th and 12th grade students who come down to the 8th grade and reach all 4,000 8th graders with five classroom periods of actually skills development, how to deal with social pressure that makes you feel like you ought to become sexually involved, all those things you see on MTV, how to deal with the peer pressure that other kids say everybody is doing it. It is just a part of growing up. It is just a part of a dating relationship or you are not a man if you do not become sexually involved.

Since one-half of our teen leaders are male, boys can stand in front of the class and role model and say, well, if the other kids said I was not a man because I was not having sex, here is what I would say or here is what I would do, teaching them skills to handle problem situations that they run into.

We have girls in our clinic who say, gee, he took me out to a rock concert and for pizza afterward. What could I do? He said I owed him something. But we teach them you do not owe anybody anything. As a matter of fact, there are ways to handle that situation. You can say I will treat next time or next time why do we not go someplace where it does not cost money? Those simple, practical skills about how to manage sexual feelings in relationships, levels of physically expressing affection, how to think in advance about the level that you want to stop at and be able to communicate that to the other person.

After we had been doing this program at schools for a number of years, we evaluated and we found that young people who did not have this program were five times more likely to become sexually involved in the eighth grade than those who did have the program. At the end of the ninth grade, there was still a one-third reduction

in sexual involvement, and this was among both boys who had not had sex before the eighth grade, as well as girls who had not had sex before the eighth grade.

Because we couple this with a program that does teach young people about contraceptives, we also found that if they became sexually involved, if they used contraceptives, they were five times as likely to say it was because of what they learned in school.

In addition to that, we found at the end of the ninth grade they were less likely to continue to have sex by saying, well, I tried it once or twice, but I do not have sex anymore, as opposed to young people who did not have the program who were more likely to say I have sex often or sometimes.

The wonderful thing about working with young people is there is so much room for growth and change. They do have a lot of common sense, but they need adult guidance and support to be able to manage that in this very sexually explicit world that we live in and that we make them live in today.

PREPARED STATEMENT

So, I guess my advice or counsel or plea to this particular Senate panel is that we recognize that adults in our society are not particularly good role models right now, that we reach out to adults in our society and show them and tell them how what their behaviors are doing, their attitudes are doing, are affecting our young people today and how adults in our society can change their attitudes and behaviors to be better role models, and then we basically set up the mechanisms to provide programs to help young people deal with the pressures that we put on them so they too do not have to pay the one pregnancy penalty for information that they need.

Thank you.

Senator SPECTER. Thank you very much, Ms. Howard.

[The statement follows:]

STATEMENT OF MARION HOWARD

What is the Problem?

Why do we have a continuing unacceptably high rate of births to young people? The basic answer is clear--**it is our culture.** Adult attitudes, values, and behaviors surround young people with inconsistent, often conflicting and, many times, negative messages about responsible sexual behavior. The impact of change on youth from a more conservative and consistent culture to this new one is compounded by the fact that the beginning age of fertility has been lowering three months every ten years for the last 100 years. Whereas a hundred years ago, on the average, girls did not become fertile until around age 17; half of all girls now have the capacity to become pregnant before age 12! Boys' fertility follow roughly a year later.

The result of these two changes is that we now have a generation of youth who are making decisions about sexual actions in a sexually provocative environment, without having completed some of the most important phases of their growth and development, including their cognitive, psycho-social, and moral growth. Indeed, without yet knowing fully who they are, and without yet being able to clearly see the consequences on their actions, young people are deciding to have sexual intercourse, deciding protection is an option rather than a necessity, and deciding to have a baby before they have a chance to complete their basic education.

What Can We Do?

It is unlikely we can quickly change our culture. Therefore, as our young people grow to sexual maturity within that framework, it is important to help them manage as responsibly and as consequence-free as possible. Three approaches--*insulation, minimization,* and *delay of onset*--have been suggested as a way to help youth manage their participation in a variety of negative health behaviors such as smoking, drinking, or other drug use. It is worthwhile to examine these approaches with respect to reducing teen pregnancy.

Insulation

As applied to interventions in the field of teenage pregnancy prevention, it is clear that insulating young people from the harmful effects of sexual behavior has been the path most chosen by health professionals over the last two decades, and the one still most strongly advocated. Since pregnancy at a young age is seen as being harmful to both the teenage parents and their offspring, proponents of health service intervention have pushed for provision of birth control services to young people, seeing use of contraceptives as potentially the most successful intervention in pregnancy prevention.

The difficulty in applying this insulating approach has been the ambivalence of society regarding sexual behavior, particularly sexual behavior among young people. Although there generally has been positive acceptance of other health measures designed to protect children--such as childhood immunizations, there has been no such mandate for contraceptive use. For example, it is acceptable when schools require immunizations before children can attend, but schools become battle grounds when condom distribution is suggested. Schools may allow comprehensive health services to be set up within their walls, but the provision of birth control devices in such health centers may be forbidden. Even the notion of providing factual information in school classrooms about the various kinds of birth control methods and how to use them effectively, has met with strong opposition from many sources.

Adults who wonder why adolescents do not use contraception often cannot conceptualize the world as it is experienced by adolescents--a world in which confusing and conflicting messages occur. For example, there is no advertising of contraceptives on television, even for adults. There is no role modeling in the movies or on television of adults using contraceptives either as a part of daily lives (such as taking a birth control pill in the morning) or using protective methods before intercourse (such as foam and condoms.) There are no sanctioned supportive measures (such as using school buses to transport young people to health facilities to obtain birth control.)

Because society is fundamentally ambivalent about sexual behavior among youth, there are no public attitudes that make teenagers who use contraceptives "heroes" or "heroines" in their own lives -no one publicly conveys they are proud of youth who use contraception. When birth control information is given to young people, there are no "pep talks" and rallies to support its use. There are no incentives or rewards.

Most often, it is left to adolescents to overcome their own ignorance and concerns about birth control, to find their own motivation to use birth control, to arrange their own transportation to get to services, to develop their own courage to face adults, many of whom are likely to disapprove of adolescent sexual behavior and, by association, their need for and use of contraception. Lack of perceived parental support for contraceptive use further complicates adolescent efficacy in this area. (One study of suburban youth indicated that over 40% of adolescents would seek birth control only if their parents didn't know.)

Given this climate, it is not surprising that numbers of school-age youth do not use contraception at first intercourse nor with consistency on subsequent occasions. It also is not surprising that sex education by itself does not improve contraceptive use by adolescents under age 17. For example, a knowledgeable 13-year-old is no more likely to use contraceptives than is an uninformed 13-year-old. Only when adolescents are older and reach some kind of independence and psycho-social maturity do they seem to be able to use birth control with any degree of consistency and effectiveness. The 400,000 abortions to teenage girls annually are vivid testimony to the fact that adolescents do not use contraception well, even in the face of totally unwanted pregnancies.

Minimization

Another suggested strategy is to help young people *minimize* their involvement in sexual behavior, thereby reducing the likelihood of harmful outcomes. This might include limiting involvement in sex to short term experimentation or limiting the number of partners an adolescent might have over an extended period. Although pregnancy can occur at any time, satisfying curiosity about sex, particularly if birth control is used, and then not engaging in sexual relations further, could reduce the possibility of pregnancy. Since adolescents who obtain birth control have difficulty in using it consistently, minimization of sexual involvement could reduce the likelihood of pregnancy, even among youth who have sought out contraceptive methods. This approach rarely has been tried with adolescents. Because of societal ambivalence about teenage sexual involvement, interventions aimed at minimizing (not total prevention of) sexual involvement have not been forthcoming. Since it is difficult for the adolescent to envision the future, and thus the number or dating partners they might have in their teen years and beyond, without intervention, it is difficult for them to set limits on themselves. Often they think that the particular person in their lives they are sexually attracted to at the moment will be there forever.

However, *minimization* has been applied to reduction of repeat teenage pregnancy. Sixty percent of adolescents who give birth to child under age 16 are likely, without intervention, to give birth to another child while still of school age. Rapid repeat childbearing is associated with increased risk for poor pregnancy outcome. Therefore, some programs have been designed to provide interconceptional care to adolescents who already have given birth to one child. They focus on minimizing the amount of childbearing at a young age; helping young people delay further childbirths until they are older. Such programs are heavily birth control oriented but also can encompass helping the young mother find child care, get back in school if she has dropped out, undertake job training, and solve other problems that may have led to or been caused by the pregnancy. Research on one such program indicated that with intensive intervention, 80% of low income minority youth who give birth age 16 and younger can be helped to remain pregnancy free until they are out of their teens. However, this approach to *minimization* still makes the young person pay a "one pregnancy penalty" before intensive support is given.

Delay of Onset

Yet another approach is to help adolescents delay the onset of behaviors that have potentially harmful consequences. This approach may be a particularly appropriate one for application to sexual behavior because sexual intercourse is the one behavior (as opposed to smoking, drinking, or drug use) that adults expect and want young people to engage in later on in life.

Delaying the onset of sexual behaviors long has been an implicit approach to preventing teenage pregnancy. Most of the older adults in our society grew up in a time when it was generally understood by adults and youth alike that young people were not to have sexual intercourse. However, recently it has been necessary to make messages about remaining abstinent more explicit. This alternation has been needed because of a change in adult sexual values and behaviors that has led to a change in adolescent sexual behavior.

In the 1970's, abstinence among adolescents was the norm. For example, only 4.7 % of 15 year old girls had had sexual intercourse. By the late 1980's, however, over five times as many girls were sexually involved at that age. The inappropriateness of elementary and junior high students becoming sexually involved galvanized thinking about the need to give actual assistance to young people to help them remain abstinent, particularly as many such adolescents

indicated what they most wanted to know was how to say no without hurting the other person's feelings, and the majority of sexually involved youth were saying they had sexual intercourse because of social and peer pressures.

The philosophy of *delaying the onset* is to allow young people to postpone behaviors with potentially harmful consequences until they are older and can more clearly see the implications of their behavior on their future. The delay also is intended to help young people postpone such behaviors until they are old enough to take full responsibility for the consequences of their actions.

Interventions that Work

One group of programs that appear to offer good promise of reducing teen pregnancy are programs that incorporate more than one approach, for example, *insulation* and *delay of onset*. These more successful programs are aimed at helping young people manage their sexual behavior, both refraining from sexual activity and protecting themselves if they do have sexual intercourse. A few examples of these kinds of programs are *Reducing the Risk*, *Postponing Sexual Involvement*, the *Baltimore Pregnancy Prevention Program*, the *Group Cognitive-Behavioral Training Program*. These program models have received intensive evaluation and variously have demonstrated reduction in sexual involvement, increase in birth control use, reduction in teenage pregnancy.

The successful programs tend not to be didactic but more experiential for young people, helping them to personalize risks. Such programs are developmentally appropriate, presenting information and services one way to younger adolescents, another way to older adolescents. They also are skill-based, helping young people actually develop abilities to deal with social and peer pressures toward sexual involvement or negotiate systems and interpersonal relationships to obtain and use birth control.

These programs try to change perceptions of peer norms--making it more acceptable to refrain from sexual activity or more acceptable to use contraception. Such programs are value based--often they are designed to support a given value--such as avoidance of sexual intercourse at a young age or avoidance of pregnancy at young ages. Some of the programs also are linked to health care settings that offer birth control services.

If such programs show promise of reducing teen pregnancy, it is important to ask if they are being replicated. Indeed, although one or two of the programs are being widely used (albeit sometimes in part, not in whole), most of the programs demonstrating positive impact on youth behaviors and reduction in teenage pregnancy are no longer in existence, even in their own communities. Thus it would appear that wide-spread adoption of proven models is not related to demonstrated success alone and reduction of teenage pregnancy may well be a far more complex task than is usually envisioned from a program development and evaluation point of view. Support for the implementation and continuation of such programs is needed.

The Postponing Sexual Involvement Program

One successful program model, *Postponing Sexual Involvement for Young Teens*, and *Postponing Sexual Involvement for Preteens*, consists of a module for delaying sexual involvement that is structured so it can be given independently or added to other program modules. *Postponing Sexual Involvement* provides information designed to help adolescents explore attitudes and feelings about managing physical feelings within relationships. It also teaches adolescents skills to resist social and peer pressures to become sexually involved.

As implemented in its home community, Atlanta, Georgia, *Postponing Sexual Involvement for Young Teens* was added to a *Human Sexuality* module that provided factual information on anatomy and physiology of the reproductive system, becoming a parent, sexually transmitted infections, birth control, and decision-making. One unique feature of the combined program was that family planning counselors from Grady Memorial Hospital taught the five [5] classroom period *Human Sexuality* part of the program while trained 11th and 12th grade Teen Leaders presented the five [5] classroom period *Postponing Sexual Involvement for Young Teens* part of the program under the supervision of the family planing counselors.

Implemented in middle schools with all 8th grade students in the Atlanta Public Schools, the two-module program was able to significantly delay sexual involvement throughout both the eighth and ninth grades among low-income male and female youth who were given the program as opposed to such youth who did not have the program. (Over 4,000 youth were given the

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program, however, the evaluation was done on a sample of the poorest youth in the area, N=665). In the 8th grade, youth who did not have the program were four to five times more likely to become sexually involved. At the end of the 9th grade, there was still a one-third reduction in sexual involvement of boys and girls who had had the program as opposed to those who had not participated.

Among those who became sexually involved, if they had had the *Postponing* program, they were more likely to limit involvement in the behavior. Moreover, at the end of the 9th grade, youth who had the combined program were more likely to use birth control and twice as likely to say they used it because of what they learned in school. Although increasing numbers of youth became sexually involved from the tenth through the twelfth grades, there was still a difference between the the study and comparison groups with respect to sexual involvement at the end of the twelfth grade. (Youth who had dropped out of school were followed as well as youth who were still in school at the end of the 12th grade.) Data indicated clearly that those given the the combined *Postponing Sexual Involvement* and *Human Sexuality* modules delayed sexual involvement more than did the comparison group throughout the five year study period.

Because of the small sample size, it is important to view the data on pregnancies generated from the Ford Foundation funded *Postponing Sexual Involvement* research study with caution. At the end of the 9th grade, there was a one-third reduction in pregnancies among female youth who had not yet had sex when they had the program. However, it is important to note that this reduction was based on the program's primary effectiveness--reducing sexual involvement--because once sexually involved, the differences between the two groups disappeared. The findings on both sexual involvement and pregnancy rates for females were validated by a hospital record search conducted 10 months after students had completed the 9th grade.

The purpose of the *Postponing Sexual Involvement* program given in the 8th grade was to "buy some time" for young people, allowing them to mature cognitively and psycho-socially for a few years without sexual involvement, hoping that with added maturity they could make and carry out constructive decisions about sexual involvement and protection against pregnancy. However, since as time went on many young people became sexually involved, it would appear that booster sessions in the upper grades are mandated to retain early gains in abstinence. Giving further credence to this need is the fact that, at the end of the 12th grade, most young people who had become sexually involved indicated waiting until an older age would have been better.

Meeting the Needs of All Youth

Currently young people's sexual behaviors range all along a continuum. They need appropriate assistance wherever they are. Combining *delay of onset*, *minimization*, and *insulation* in an age-appropriate single program strategy or in cooperative multi-program strategies can provide a positive underpinning for such efforts. For example, greater funding for school/health agency cooperation on teen pregnancy prevention could increase the likelihood of helping students receive information and services--not just in clinics in schools, but in already established community health services. As important, health agencies would be encouraged to facilitate innovative programs in schools, including those aimed at delay of onset.

Not all funding for programs that could make a contribution to helping youth better manage their sexual behavior in today's society, needs to be new funds. Allowing existing funds to be used more creatively would help. Title X programs, for example, are traditionally judged on how many patients they see in their family planing clinics, not on how many teens don't need to come because the programs reached out and helped them delay sexual involvement.

A Note of Caution

As we struggle with how to prevent teenage pregnancy, and even have some successes, defining *teenage pregnancy prevention* as the problem may structure thinking about solutions in ways that prevent the very outcomes we are trying to achieve. Indeed, teenage pregnancy itself may be a consequence of other problems that we as a society are facing. If so, is it realistic to expect that individual program strategies can overcome fundamental societal deficits in ways that will lower teenage pregnancy to acceptable levels? For example:

- ***Is the real problem that biological maturity has outstripped psycho-social maturity for our young?***
  Puberty is now occurring earlier (average age 12 for girls) while cognitive, psycho-social maturation is not completed until much later in adolescence. Is it truly possible for immature youth to manage sexual feelings and behaviors in ways that avoid risk?

- ***Is the problem that, in our society where unskilled untrained labor is not needed, we have no role for youth until they are out of their teens and educated?***
  Do young people think they have to have sex or have a baby to BE SOMEBODY because they are coming through systems that do not show them we love them, care about them, and have an immediate genuine need for them?

- ***Is the problem that the media keeps sexual images constantly on the minds of young people and shows sex in a superficial stereotyped way?***
  Cross-culturally, young people usually have become sexually involved around the time of puberty unless there have been strong societal restraints. Currently there are few societal constraints; indeed, there are many societal pressures *toward* unhealthy sexual involvement.

- ***Is the problem how we view parenthood or are acting as parents?***
  For the first time in 1990, the majority of children in the United States will have lived, at one time or another, in a single parent home. Today, children may see one or both parents date and become sexually involved with someone to whom they are not married. Are parents so involved with themselves and meeting their own needs, that they do not take time to meet the needs of their children? Do parents need to be given a clearer indication of how their changed attitudes and behaviors affect our country's youth?

- ***Is it the economic situation in our nation and our communities?***
  Adolescents who have little or no hope of finding jobs that will help them escape from poverty are less likely than others to see the merit of future planning, including family planning. Racial discrimination compounds that problem. Even if one graduates from high school, if the best job one is ever going to have is behind the counter at McDonald's, why postpone parenthood? If the violence makes one unsure there will even be a future, why postpone anything?

- ***Is the problem that we tend to compartmentalize our thinking and responses?***
  When we ignore that young people who engage in sex at young ages are more likely to be involved in smoking, drinking, or drug use as well, we are less likely to help youth help conceptualize alternatives for living encompassing the message that *being drug free, pregnancy free, and infection free is a way to be free to be whatever they want to be.*

- ***Is the problem that adults have not resolved problems between the sexes and this legacy is being passed to the young?***
  Battering, rape, and incest affect more women in our country than any other industrialized nation. Who teaches young men and young women to be caring and respectful of each other? Without that as a basis for a relationship, how can issues of abstinence and pregnancy prevention be resolved by youth?

Teenage pregnancy has become an enduring problem in our society. There are no simple solutions. We need to hold up a mirror to ourselves and other adults around us and ask: how do we, how does our society, role model what it means to be a man, what it means to be a women, what responsible sexual behavior is? What do we need to change? How can we do it? When we can answer that, we will be closer to a solution of preventing teenage pregnancy.

STATEMENT OF LAKITA GARTH, BOARD OF DIRECTORS, ATHLETES FOR ABSTINENCE, ON BEHALF OF THE A.C. GREEN YOUTH FOUNDATION

Senator SPECTER. Ms. Garth, the floor is yours.

Ms. GARTH. My name is Lakita Garth and I direct a program, athletes for abstinence, which is based in Los Angeles, CA, which is really a speakers bureau that goes out into the public school systems, to youth programs across the country, and basically we talk about abstinence.

I know we are all here because we are concerned about the rising teen pregnancy problem, babies having babies, babies having AIDS, babies having STD's, but these are all symptoms of a greater problem of babies having sex. It seems the great consensus is that we are all agreeing abstinence, yes, abstinence. Of course, that is the best way.

But like the Surgeon General said, there are several approaches that have been taken to solve the teen pregnancy problem. She

mentioned abstinence, but within that, there are so many definitions that people use for the word "abstinence."

When we go out and we teach abstinence education, it is not, as I have heard it in some sex education classes, mutual masturbation and undressing in front of your partner, all these things. We teach abstinence as instilling in young people self-control, discipline, and the delay of self-gratification. That is what—when I am using the word "abstinence"—I do not know if everyone else here is, but that is what we are using when we are talking about abstinence.

The thing is the Surgeon General also pointed out the sharp rise in the teen pregnancies and other ailments in our society over the last 20 years, since the start of the 1970's. The abstinence based education was not the message that has been given over the past 20 years. It has not. It has been mentioned as a side note, but for the most part, it has been comprehensive sex education.

If we look at the congressional budget report which basically shows that since we have been teaching comprehensive sex education, we have seen a 397-percent increase in the number of teenage girls in subsidized birth control programs, a 266-percent increase in the number of girls who use contraceptives and still got pregnant, a 107-percent increase in abortions, and a 93-percent increase in the contraction of sexually transmitted diseases. So, what we have been doing over the past 20, 25 years has not been working.

We all agree abstinence, abstinence, abstinence, but we use it as a side note. Really when we go in and we talk to these young people, what we talk to them about is abstinence is your best choice. Abstinence is not an equally as good a choice as anything else you can do. That is just like saying never using drugs is just as good as using a clean needle. The two are not the same and they cannot be compared, and to do so is basically irresponsible and it is a disservice to our young people.

That is where I deal with. I am 25. I go out. I have unwed mothers who live with me. I take them into my home, and this is the message that they hear. Abstinence? Is that not a growth on the back of your neck? No; that is an abscess. Some of these kids have never heard of the word "abstinence" and they go to public schools every day.

So, our goal is to reduce the number of sexually active teens. If you look at the U.S. Public Health Service report, it shows evidence that the earlier a person starts having sexual intercourse, the more sexual partners they are likely to have over a lifetime, which basically increases the risk of them becoming pregnant and incurring sexually transmitted diseases.

So, I am saying if you have, let us say, in a small junior high school or a small high school, 100 sexually active girls per se; 10 percent get pregnant. Well, that is 10 girls. Well, if you take that 10 percent of 1,000 girls who are sexually active, that is 100 girls. So, we are talking about reducing the number of teenagers who are sexually active.

Basically Diane Sawyer did an interview on ABC with young girls here in Baltimore who had received the Norplant implant, and all the girls who were sexually active, she interviewed them. They all said without exception they wished they had not had sex. She

asked them how long would they have waited. They said we would have waited until we got married. That is every single one of them. That includes the SECA survey of 59 percent of sexually active girls have said they wished they had not initiated sex at such a young age.

The point I am making is we have missed the boat somewhere in not providing them abstinence as basically their best choice. We mention it in a side note and then we show them all the different things that they can do besides having sex. We did not do that for the drug campaign. We did not say do not use drugs, but let me show you how to use the correct cc amount in which to shoot up so you do not get an overdose. We did not do it because it was ludicrous.

PREPARED STATEMENT

So, what I am saying is with these kids, they are asking out in so many different ways, but I do not think we are supporting that. In wrapping that up, we cannot discuss teen pregnancy in a vacuum in the light of STD's, AIDS, the emotional, social, economic immaturity of these young people because Norplant we discuss, but AIDS does not care about a Norplant, especially when I get a letter from a school in which they did a blood drive in their area and this is in Orange County, a very affluent community, where in their blood drive, nearly 1 out of 10 high school students who donated blood was tested HIV positive. Norplant does not care about AIDS. So, we cannot just talk about that in a teen pregnancy problem.

I know I have to stop now, but thank you.

Senator SPECTER. Thank you very much, Ms. Garth.

[The statement follows:]

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STATEMENT OF LAKITA GARTH

ATHLETES FOR ABSTINENCE (AFA) is a not-for-profit program made up of athletes, celebrities, community and corporate leaders, professionals, parents, and concerned citizens. AFA addresses the problems that teens face today when it comes to making the best and responsible decisions regarding their sexual behavior. In our presentations we pose some frank questions as well as frank answers about sex and its consequences. Pressures from peers and the media toward sexual relationships, are major influences in a teenager's decision-making process. Through a multi-media presentation, statistical information, and the sharing of personal experiences from trained speakers with various backgrounds, not only shed light on the emotional and physical consequences of pre-marital sex but encourages and empowers teens to choose and live out an abstinent lifestyle. When you encourage self control in the area of sexuality, you are teaching a skill that will inevitably be used in other areas of an adolescents everyday life. By instilling this discipline, they are more easily freed-up to focus on more important long-term goals and objectives. A survey of 6.5 million juniors and seniors in high school, the top 5%, (published in Newsweek Oct '86 and Issues Jan'82) clearly shows that many outstanding young people have not chosen to succumb. It revealed that more that 75% of these leaders have never had sexual intercourse. 1/2

The U.S. Public Health Service (PHS), shows evidence that *the earlier a person starts having sexual intercourse, the more sexual partners they are likely to have over a lifetime, therefore, the more at risk to becoming pregnant and incurring STD's.* In addition, virtually everyone agrees that the only 100% sure way of not getting pregnant and preventing the transmission of HIV/AIDS is to abstain from sexual intercourse until one is in a lifelong, mutually faithful, monogamous relationship with an uninfected partner, especially one who does not use IV drugs. Because there are risks of pregnancy with every contraceptive device other that abstinence as described above, the abstinence message then becomes the best, or optimal message that can be given. Regardless of this fact, our government continues to spend the vast majority of its time, money, and efforts promoting contraceptive education.

The title XX Family Life Act with the U.S. Department of Health and Human

Services (HHS) is the only federal government office that provides funding for abstinence-based programs. Unfortunately, many of these programs were limited in their abilities to evaluate outcomes because of the small amounts of funding available from Title XX. The office had approximately $7.8 million awarded annually to support demonstration programs throughout the country, only about $2.5 million of that could be used for abstinence-based programs. This compares to an estimated $50 million used for contraceptive service and counseling for adolescents in the Title X Family Planning Program. (Incidently, a portion of Title XX monies were also required for family planning services for adolescents).

Rather than recommending an increase in the abstinence-based demonstration funding program and working out the kinks that hindered funded projects from realizing their stated objectives, the Title XX program is now slated for a quick demise. Nonetheless, a number of the Title XX programs, such as the American Home Economics Association's Project Taking Charge (PTC) have had very impressive outcomes. Students in the PTC program were four times less likely to initiate sexual intercourse than students who were not in the program.

The entire concept of abstinence as perpetuated in abstinence-based sex ucation curricula has frequently been misrepresented. To teach abstinence in the schools is not to teach religion or fear. An effective abstinence-based curriculum focuses on universal values and activities such as discipline, self-control, delaying self-gratification, respect for self and others, developing and maintaining meaningful relationships, developing future goals and understanding and respecting the potential joys and dangers of sexual involvement. This type of education helps young people understand why it is important to delay sex, teaches them the skills to actually resist peer pressure, provides support from peers, teachers, parents and the community in general. All these factors combined, will help them follow through on their decision to delay sexual activity and find something positive they can say "'yes," to as they say "no" to sex.

Promoting abstinence, especially abstinence until marriage, has been viewed as making a moral judgement about one's behavior, an act that is totally unacceptable to many. However, the vast majority of Americans across social, economic, and religious

barriers recognize and express very strong support for the institutions of marriage and the two-parent family, and desire to strengthen, not abandon these institutions. *The December 14, 1993 USA Today quoted President Clinton, "...this country would be much better off if our babies were born into two-parent families."* If we believe this, then the emphasis should be on strengthening the societal norms that provide the foundation for young people to be responsible through challenging them to develop self-control and character, even at the cost of sacrificing achievement of sexual gratification as a teenager.

A rather obvious conclusion about helping kids avoid premarital sex is that rather than presuming the teenagers are going to have sex anyway, our collective strategy for combatting teen pregnancy and STD's should be similar to the approach we have taken on successfully curbing adolescent drug addiction, alcohol abuse, and smoking -- we should encourage teens to "just say no." It is extremely irresponsible to imply to young people that they can control their passions in the area of violence and other abuses but cannot control their sexual urges. If young people are having sex ... with or without a condom ... they are still placing themselves at significant risk for unwanted pregnancies not to mention disease, economic and educational poverty (a breading ground for violence, substance abuse and welfare). How often have you heard, or read in one publication after another, "Teens are going to have sex anyway and there's nothing we can do about it"? As a result, instead of a message to actually stem the rising tide of teen pregnancy, a far less effective one is zealously promoted, based on a prejudgment of an adolescents capacity, or lack of it, to adhere to counsel that is in their own best interest.

Diane Sawyer reported on ABC News that she made a sad discovery in the course of her report on Norplant, the long-term contraceptive made available at schools in Baltimore: "Every single one of those sexually active girls confided to us they wish they'd said no (to sex)." When pressed to say how long they would wait to have sex, each girl replied, until they got married. The sad part is that abstinence until marriage was probably never seriously presented as a viable option for theses girls. Someone made the determination that it was an unrealistic and an unacceptable concept for them. Perhaps because they were Black, poor and in the inner-city. If it is agreed that

waiting to have sex until a life-long, mutually faithful, monogamous relationship is the best message that can be given to our young people, then why is this approach only dealt with briefly in most sex-ed curricula...almost in passing, or as an equal option among other sexual behaviors? Where are the monies, public service announcements, curricula, brochures, and videos funded by the government to promote this message?

Effective abstinence-based education have proven to have lower teen pregnancies as well as lower occurrences of STD's. Sexual intercourse is not portrayed as something evil or merely another form of casual recreation. To experience sexual pleasure that does not turn into emptiness and deeper longing when the climax is over requires a healthy relationship built on caring, trust, and love. Abstinence-based programs encourage youth to build a solid foundation in developing closer relationships by concentrating on better communication, trust, honesty, patience, self-esteem, and respect for themselves as well as others. These attributes are the core of any successful relationship, especially one involving two people who plan to spend a lifetime together. However, these important elements are briefly, if at all, discussed in light of the mere mechanics of sex. Many effective abstinence-based programs have seen expected results, among such groups are:

PROJECT SISTER- An abstinence-based program developed and administered by the University of California at San Diego reports that not only are program girls waiting longer to have sex, they are cutting class and using drugs far less frequently than girls in the control group, and report being more satisfied with themselves.

BEST FRIENDS- In washington, D.C. reports only one pregnancy out of the nearly four hundred inner-city elementary through senior high girls in its abstinence based program over a seven year period.

NATIONAL INSTITUTE FOR RESPONSIBLE FATHERHOOD AND FAMILY DEVELOPMENT- Is quick to share the impressive outcomes of their twelve year

old program that boasts of not distributing condoms or endorsing sex outside of marriage. Of the nearly 2,000 young men, of whom were already unwed fathers, 78.3% have not caused an additional pregnancy since participating in the program.

KENOSHA COUNTY WISCONSIN HEALTH DEPARTMENT- reports that its abstinence-based program has experienced significant numbers of previously sexually active students in their program who have made the decision to return to an abstinent lifestyle.

SEX, LOVE, AND CHOICES- is a program in the Los Angeles area which spoke to over 5,000 junior and senior high school students last year alone. Of those students surveyed, 74% made a decision to live an abstinent lifestyle. One of the main questions asked by these students was, "why aren't we hearing more about abstinence?"

If you ask Kimi Gray, president of Kenilworth Parkside Resident Management Corporation in D.C. what was the motivating factor in changing the lifestyle of adolescents in her inner-city community from that of drugs and alcohol abuse, unwed parenting, and juvenile delinquency she'll talk about how the behavior and messages from the adults changed. "T.V. and music the kids listen to need to change, but the most important change is how adults in the child's life behave and what they tell them. We've told our kids that using drugs and having sex were not acceptable behaviors for them. We set guidelines and boundaries and we found ways to help them be excited about learning. Instead of watching our young people go off to jail, a drug rehab center or the welfare office like we use to do, we are now sending them to college."

But what about the kids who won't listen, who are going to have sex anyway? We all know those kids are out there, but not as great a number as we might think.

- ASSOCIATED PRESS- A survey of 1,200 young people in Grady's Teen Services Program found 80% said they wanted to know more about how

to say no. Testing of the program in Atlanta and Cleveland found numbers of young people who were "tremendously relieved " to hear a supportive message telling them that it's okay to slow down while growing up." 3.

- EUNICE KENNEDY SHRIVER- after visiting a center for teenage girls, reported that when students were asked what they most wanted to discuss, "they chose 'how to say no to your boyfriend.' They showed no interest in human biology or family planning." 4.
- EMORY UNIVERSITY- asked nearly 2,000 sexually active girls what they would most like to learn in an effort to reduce teen pregnancy, over 85%, answered, "How to say no without hurting the other person's feelings." Students (boys and girls) in the resulting program, were five times less likely to become sexually active than those not in the program. 5.

Though abstinence-based programs do not teach outercourse behaviors, they often do talk about condoms and contraceptives. But those devices are discussed in a realistic manner only after significant effort is made to encourage and support a youth to delay sexual involvement. Accurate facts are given about their use and effectiveness, but they do not become the highlight and emphasis of the presentation. Settings such as family-planning clinics are very appropriate for more detailed information about condoms and contraceptives. Instead of abstinence being the focus over the past 20yrs, comprehensive sex education has been the main curricula used in our public school systems. The Congressional budget office has reported since 1971, when Title X federal funding for family planning programs began, there has been a:

- 397% increase in the number of teenage girls in subsidized birth control programs.
- 268% increase in the number of girls who used contraceptives and still got pregnant.
- 107% increase in abortions.
- 93% increase in the contraction of STD's. 6.

Although these numbers note the incredible increases in the teen pregnancy epidemic we cannot overlook the vast amounts of expenditures and resources that have been used in this losing battle. The Associated Press reports that in one year alone, "Teenage child-bearing cost(s) the nation $16.6 billion." This estimate includes payments for AFDC, Medicaid, food stamps, as well as the costs of administering these programs. This figure represents minimal public costs in that it does not include other services such as housing, special education, child protection services, foster care, day care and other social services. 7. If this doesn't seem expensive, how much more can we expect to spend on nationwide Norplant implantation and government funded abortions?

As far as protecting the youth from pregnancy and sexually transmitted diseases, the goal should be to do all that is possible to decrease the numbers of adolescents who are sexually active. Consequently, decreasing the numbers of those who are at risk. Then, for the limited number who may still be sexually active, to find the most effective, and appropriate ways to provide the council and devices they needed to reduce their chances of pregnancy and disease in a way that does not negatively impact those who are choosing to delay.

We should applaud family planning groups, the CDC, and the public school systems for their efforts to stem the teen pregnancy epidemic and the spread of STD's. However, those who proclaim themselves to be experts in the area of prevention of pregnancies and diseases that are already on their way to decimating the future of our country, should be held accountable for their actions. The policies they promote, the services they provide, and the advice they advocate should all be weighed against time honored medical strategies and good old common sense. Each american citizen should, without hesitation, encourage the U.S. Public Health Service and every local school board to vigorously seek input from those who have been successful in reducing, not only pregnancies, but the spread of STD's and that also positively impacts other debilitating social ills confronting us as a nation. That approach is unquestionably the abstinence-based sex-education model.

If we can instill self control and discipline in the lives of our youth they will be able to concentrate on, aggressively pursue, and achieve long-term goals in their

individual lives. By encouraging them to postpone immediate self-gratification they can divert their energies to becoming mature and responsible citizens of our country, in which we can anxiously await an increased Gross National Product rather than increased Gross National Expenditures in the form of billion dollar welfare programs.

Research acquired from the Alan Guttmacher Research Institute and the Centers for Disease Control (CDC) show that everyday in America:

- 3,000 unmarried teenage girls will become pregnant.
- 1,370 of these pregnancies will end in abortion.
- 60% of those teenage girls will be pregnant again in two years.
- 96% of the girls who give birth out of wedlock will keep their babies.
- 70% of unwed teen mothers will go on welfare.
- 8,200 teens will contract at least 1 of 50 known STD's.
- 1 in 4 American teens will be infected with a STD before they graduate from high school.

The cost of teen promiscuity is staggering both in human suffering and expense to society. Yet, experts say, we have only seen the tip of the iceberg. Unless we come to terms with widespread promiscuity and the lack of effective action taken to stem the tide, it will continue to spread, with millions of Americans suffering -- many dying of AIDS. There is only one "safe" way to truly protect oneself against unwanted pregnancies and sexually transmitted diseases (STD's) -- abstaining from intercourse until one is committed to a mutually monogamous lifetime partner who is uninfected.

STATEMENT OF DARRELL GREEN, PRESIDENT AND FOUNDER, YOUTH LIFE FOUNDATION, ON BEHALF OF THE ATHLETES FOR ABSTINENCE

Senator SPECTER. Mr. Green, we welcome you here and look forward to your testimony.

Mr. GREEN. Thank you. I am president and founder of the Youth Life Foundation and the Darrell Green Learning Center. My connection with the Athletes for Abstinence is obvious, I am an athlete, and as was mentioned, the abstinence program is one of a speaking bureau. My connection is through my friendship with A.C. Green and my athletic background.

We here locally have the Darrell Green Learning Center where we work with kids on an everyday basis. I am under the belief that this issue of abstinence is an issue that concerns our world community, and that is for what we do in our center, this abstinence based education is developed to build character, discipline, delaying self-gratification, respect for self and others.

It is the same thing that we teach as it pertains to violence reduction, drug abuse, and other negative behaviors. It is the same. It is not something separate. We need these same types of attributes and tactics in our center just to develop young people who will not shoot you when you are walking down the street or who will not commit different crimes. So, it is not something that the Darrell Green Learning Center just necessarily concentrates on. It is a byproduct of trying to develop the whole child.

The emphasis must be on delaying sex until one is in a mutually faithful, monogamous relationship with an uninfected partner and not on having safe sex. Now, we talk about having safe sex through giving out condoms and implants and the like, but this must be a secondary message that we give only after we have done all that we can do to help young people make the best choices.

Our learning centers are located in housing complexes and they are run by people such as Ms. Garth who have a lifestyle of what they preach, of living monogamous lifestyles, of abstaining from premarital sex, of trying to produce a lifestyle in front of these young kids that would say you can be successful in life, you can achieve in life through academics in our center, through lifestyles that, for example, myself being in this city for now 12 years, being married, and as many have seen, as I try and present my own family to the public and say here is the family. Unfortunately, about 98 percent of our kids are without the two parent household, and that is a big problem.

What we do basically is we assist the school systems because unfortunately the American school system in my opinion is below par. So, when the kids come after school to our centers, they are taught on computers and they get their homework. They have mentors. These kids are being assisted. We are assisting the school system.

Then, on the other hand, we are assisting that 98 percent situation where there is one parent at the home. When parents are at home—I know myself coming from a single parent home, that one mother in our case that had seven kids was not always able to address all seven of us kids and whatever issues that were in our minds when we came home.

So, I support this program because it is basically what I do here anyway in my learning center program. So, I am very much strong when I talk about being abstinent because what I am seeing here in the city will allow these young kids—we do have the parents come when the kids come and register for class. Most of the parents have kids and they are a lot younger than I am. So, you do not have to be a brain surgeon to see what is going on out here.

Thank you.

Senator SPECTER. Thank you very much, Mr. Green.

Ms. Machael, Senator Harkin asked me to ask you two questions. He expresses his interest in the changes you may have seen in the last few years in the backgrounds of teen parents that you work with. Have you seen an increase in the number of very young teens who become pregnant? Have you noticed any other trends?

Ms. MACHAEL. Well, we think we have seen a difference. We have seen an increase in the number of very young teens becoming pregnant in Iowa, which I guess you would not think you would

have a high teen pregnancy rate, but it is not unusual anymore to have teens in the middle school who are pregnant.

We do have a day-care center in the alternative school. I do not think it is totally unreasonable to discuss the concept of day care centers in other schools as well.

Senator SPECTER. Well, since Senator Harkin has returned, I am going to leave the second question for him to ask or I will go ahead and ask it.

Senator HARKIN [presiding]. That is OK. Go right ahead.

Senator SPECTER. I was interested to hear that your repeat pregnancy rate for participants in your Young Moms Program is 2 percent compared to 25 to 50 percent for nonparticipants. The question is: What makes the program so successful?

Ms. MACHAEL. I think there are a lot of things that make it successful. First of all, my personal feeling is that sometimes the teens who have a sincere desire to succeed are the ones who attend those groups very regularly. So, perhaps there is a preordained success rate there.

On the other hand, the teens when they are in the group get regular contact with their peers on problem solving, on trying to give back to the community the way they have been given to, and on how to cope with the problems that teen parents have. They discuss those problems in groups week after week after week. The groups are facilitated by a woman who was once a teen parent herself, so nobody speaks down to them. They speak with the teens. The facilitator says I have done it, you can do it too. Let us all talk about how to do this together.

Senator SPECTER. Ms. Garth, you have commented about having missed the boat for 20 years. Things are not working, and I agree with that. You talk about youngsters not knowing what abstinence means. Mr. Green has talked about the role models that he gives for monogamous marital relationships and no premarital sex.

What do you do beyond that to succeed in articulating and encouraging abstinence?

Ms. GARTH. The thing is that when we go and we talk to these young kids, we do not shake our finger and say just say, "no." We teach them skills in which we teach them refusal skills. We teach them why reasons to wait. Many of them do not even know the consequences of not waiting. Many of them are told that maybe they should wait in the first place.

Senator SPECTER. They do not know they will become pregnant?

Ms. GARTH. When we are talking about the pregnancy rates, how many young kids—see, the thing is that somehow we need to educate, educate, educate, educate the kids on sex, but at the same time we need to tell them the consequences of their actions.

For instance, even in the black community, we have had more education about sex education, more opportunities for so many different choices than we have ever had. Yet, 67 percent of all black children according to USA Today are born to single parent mothers, and less than 45 percent of black families are headed by two parents.

At the turn of the century, we had less education and more racism, less opportunity, the whole 9 yards, but 85 percent of all black families were headed by two parents and the teen pregnancy rate

was less than that of the white population. So, somewhere in there something has gone wrong.

When we go and we talk to these kids, we talk to them about self-control, self-discipline, delaying self-gratification, using that energy to plan for your future. I grew up with a single parent mom who raised five of us in a community that was not fostering the various things that we just said, but my mother did instill those even as a teacher. She was a public school teacher. She instilled that. We used that. In the area of sex, that one skill, we channeled it to every other area of our lives. She raised a doctor, a lawyer, an engineer, a naval serviceman. I graduated from a major university in less than 4 years.

The thing is when we were living in the household, it was expected, you will not have sex while you are living under my roof because you are not able to deal with the consequences. But somehow we are afraid to tell kids you are too young to have sex. We can tell them you are too young to vote, too young to drive, too young to drink, too young to smoke, too young to do all these things, but we are afraid to tell them for some reason you are too young to have sex. The bottom line is impressionable minds live up to the expectations that are put upon them.

Senator SPECTER. Ms. Garth, you were present during the testimony of Dr. Elders and the discussion which Senator Harkin and I had as to whether there is any connection between the welfare payment and teenage pregnancy. I would be interested in your views and also, Mr. Green, your views on what you think about that subject. Do teenagers or others have children in order to get welfare payments in your view?

Ms. GARTH. I have not read any studies that the Surgeon General may have access to, but in the girls that I come in contact with, with the teen parents that have come and lived in my home, that was not the case for them. But I did meet some of their peers who, in essence, that was not the whole purpose, to have sex so I can get pregnant so I can get a check. It was like, well, if I get pregnant, I can always get AFDC. So, the motive was not a contrived plan to have children.

I am sure there are those women who do, but the thing is, they know it is there. It is a safety net, and if the safety net perhaps was not there, maybe they would think twice. Hey, the Government is not going to take care of me if I do this. Maybe I am going to have to take care of myself. So, it has been more or less that that has been the case.

Senator SPECTER. Mr. Green, what do you think about that?

Mr. GREEN. Well, I think as far as from our perspective, concern about children being abstinent, I think the more that we give them in terms of a safety net, if you would, the more apt they will be to not adhere to this which we know to be 100 percent effective. So, the more that you allow—we have all been kids before. The more string you give me, the more I am going to take. But unfortunately, in this case the more string they take, the results and the consequences now in today's society through AIDS it is death.

So, we should not be playing around with this issue and we should not be thinking about all these different ways in which you can still do this thing. It is like out here in the drug situation. You

say, well, we will give everybody needles. We should not function that way. So, I am very much opposed to that.

Senator SPECTER. Thank you.

Dr. Howard, the programs which you have instituted, as you outlined them, have statistically demonstrated that they cut down on premarital sex and that they also cut down on teenage pregnancies and that you have had these sex education programs and you also teach about contraceptives. My question is what community resistance, if any, have you had to this very direct approach of sex education and instruction about contraceptives?

Dr. HOWARD. Part of the program we do is to also have a postponing sexual involvement program for parents so that they can come and learn how to reinforce the skills that their young people need to postpone sexual involvement.

Senator SPECTER. Did the board of education agree with your program about sex education and the instruction on contraceptives?

Dr. HOWARD. We are actually written into the formal guidelines for the Atlanta public schools that this program will be given in the eighth grade and will be taught by the teen leaders and by the nurses and counselors from my staff.

Senator SPECTER. So, it is in the rules——

Dr. HOWARD. So, it is in the actual guidelines.

Senator SPECTER [continuing]. Sex education and education on contraceptives.

Dr. HOWARD. Right and contraceptives. I think because parents and the community do understand that it is our first choice that young people postpone sexual involvement, they also do recognize the need that for young people who do not choose to make that decision, that they need support for using contraceptives so that they, as I said, do not pay the one baby penalty, do not have to bear the thought of losing their life through AIDS, that that is important too.

In other words, our three strategies really are to help young people postpone sexual involvement, to basically delay it until they are older and can more clearly see the consequences of their action, to insulate them against the harmful effects of that behavior by helping them use contraceptives and protect themselves, and then also to minimize their involvement in that behavior so that they do not get, as the other panel members have mentioned, a number of partners over time which exponentially increases their chances of getting sexually transmitted diseases.

Senator SPECTER. Is there any consideration for providing contraceptives to them?

Dr. HOWARD. Well, as I said, I direct a family planning clinic, so any young person can come to my clinic and get contraceptives as they need them.

Senator SPECTER. Is that information available in the school itself?

Dr. HOWARD. Yes; we actually take birth control methods right into the classroom, show them what a condom looks like, show them what foam looks like.

Senator SPECTER. And you tell them if they want one, they can come to your——

Dr. HOWARD. We teach them all the places in Atlanta that they can get these services. We are not the only clinic. But the same counselor who presents the program in the schools is also the person they can see in our clinic when they come. So, there is a very nice school/health linkage in that they already know this person, they know that this person advocates abstinence, but is willing to help them should they need those services and they can come to our clinic and get those services.

Senator SPECTER. Any community resistance or objection to that?

Dr. HOWARD. At this point no, because I think, as I said, they know that our preference is to have young people abstain but they also realize that young people need these other services as well. So, we have had a great deal of community support.

The difficulty is when you serve young adolescents, you cannot serve them the same way as adults. We have to see them minimally every 3 months because they are growing and changing, and there are a lot of problems with being sexually active. So, we handle them on a case-management basis in which they see the same counselor every time they come. Those are expensive services to deliver, more expensive than regular family planning.

Senator SPECTER. Thank you, Dr. Howard. I yield back to you, Mr. Chairman.

Senator HARKIN. Thank you very much, Senator Specter. Again, I apologize. I could not get my amendment up anyway and I decided this was more interesting and more important than what they were discussing right now.

Senator SPECTER. We thought you had gotten it passed.

Senator HARKIN. No; I could not get it up. They moved on and I will have to come back to it later on, but I wanted to get back here for this because we can talk all we want to about health care reform and we are going to get it through and it is necessary, but if we do not get a handle on this problem, I do not care what kind of health care reform we have, our ship is still going to go down. We have to get a handle on this problem.

I just started to read through some of the testimony since I missed it. I was taken with your testimony here, Ms. Garth, on abstinence when you said:

> The entire concept of abstinence as perpetuated in abstinence-based sex education curricula has frequently been misrepresented. To teach abstinence in the schools is not to teach religion or fear. An effective abstinence-based curriculum focuses on universal values and activities such as discipline, self-control, delaying self-gratification, respect for self and others, developing and maintaining meaningful relationships, developing future goals, and understanding and respecting the potential joys and dangers of sexual involvement.

So, again, just to clarify this, what you are proposing is something more than just say no.

Ms. GARTH. Yes; definitely.

Senator HARKIN. A lot more than that.

Ms. GARTH. A lot more than just say no, which is basically what we did—the drug campaign. A lot of times we did just say no. We told them the consequences. We gave them role models of people who did not use drugs, people who did and said, look, do not go the way that I did and gave them refusal skills. What do you do when you get in this situation and someone is trying to offer you drugs, that type of thing. So, it is more than just say no.

Senator HARKIN. It seems in many cases that our education system allows a lot of young people to have a lot of free time on their hands. In fact, it was interesting. The point was just made in the hearing I just came from. I had mentioned I had been down here talking about teenage pregnancy and what Dr. Elders had just said because that was sort of the context of school-based health education programs. I forget who it was made the point that one study had shown that—I forget the percentage, but an overwhelming percentage of teenage pregnancies occur between the hours of 4 p.m., and 6:30 p.m. I see you nodding. Is that true? Is there some basis for this?

Dr. HOWARD. The majority occur in their own homes.

Senator HARKIN. Well, this gets to you, Mr. Green. I am getting to you now. I remember when I was in high school. You have a sports team. You have a football team. You have a basketball team, baseball, and stuff, and of course you want to win all the games. So, they pick the best athletes for these programs, and then everyone else, well, there is not much for you to do. So, we found that after school a lot of times obviously the really good athletes had things to do.

It is also true of women now. It was not true when I was in high school. They did not have women teams. We do now. It is the same thing with women. Women's basketball, they pick the best because they want to win all the games.

I am just wondering if you look at this and you say, well, if this is what is happening, it is happening at home. They are latch key perhaps or their parents are not home. They are out working. Maybe we need better school-based programs after school for these kids. I just wonder from an athlete's standpoint involved in professional sports like you are, how do you see school-based athletics? Is it exclusionary? They just pick the best like you? Maybe there are some other kids that could get involved in different programs of athletics even though they are not the best.

Mr. GREEN. Well, I am not a real strong advocate of athletic programs. Athletics has been my career. I started football in the 11th grade which would be somewhat late.

But as far as I am concerned, what we do here in Northeast D.C., kids come after school. We have kids since October 1993 with perfect attendance. I think the case is being available to the children every day and providing them with some constructive activities and that is, first of all, with just coming in and doing their homework and having computers and having somebody who loves them and cares for them.

These kids are missing that basic element of love, and people say, well, how in the world can you have a 9th grader that has had perfect attendance since October? Well, it is simple. We have been there. We have loved them. We have cared for them and we have painted a picture. We have given them a vision for success. We have given them love and we have provided them with all those things that unfortunately they are not always necessarily getting at home either because there is no one there because they are at work or whatever. The people at home may be inadequate in terms of meeting those needs.

There is not enough football and basketball in the world that we could implement for kids that is going to help them make good, solid decisions. I remember after games late at night you come home and they have the little party. You have to make a decision sooner or later. You cannot play basketball and football forever. So, I am not a strong advocate of sports. We do not do any sports with our program. I think that in terms of building character and discipline, it is going to take human beings.

I unfortunately do not think that we can do it at the school. I think that the kids need to leave the school and come to another facility. I am just plugging our program because our facility is right there where they live. We are right there where they are. We know their parents. We know the management. They know us. We know them. So, in terms of the school system——

Senator HARKIN. Most of what you said I think I would tend to agree with, but for the last little——

Mr. GREEN. I think we will be doing more of these meetings.

Senator HARKIN. But for the last part of it. I would say that it depends really on the school. If you have a dilapidated, rundown school that does not provide anything, of course you need a different setting, but if you have a great school that can provide a lot of different things after school hours, whether it is auto mechanics or whether it is homemaking or whether it is teen living programs or sports, there is a variety of different things that are offered. Obviously it depends on the wealth of the school district. If you have a wealthy school district, they can provide all those things. If you have a poor school district, they cannot.

Mr. GREEN. I would have to agree with you on that, yes. I think that makes sense.

Senator HARKIN. So, it just depends.

Mr. GREEN. Unfortunately, that is just a dream. I have never seen that before, but maybe you are right. Maybe they exist.

Senator HARKIN. Oh, they do. I'll take you to some of them.

Mr. GREEN. In D.C.?

Senator HARKIN. Oh, no, not in D.C. Oh, no, not in D.C. [Laughter.]

Mr. GREEN. My mind is more set to here where I work.

Senator HARKIN. Yes; not in D.C. and not in your inner cities anywhere. I am talking about in some of your wealthy suburbs and places like that you will find those kinds of schools. As I say, it depends upon the wealth of the school district more than anything.

Mr. GREEN. That is true.

Senator HARKIN. Ms. Machael, one thing I just wanted to cover with you. I think a lot of people tend to see teenage pregnancy as a real urban problem, but we come from a rural State, small towns, small communities. I believe you have testified that it is an ever-increasing problem there also. So, it is a rural problem as well as an urban problem?

Ms. MACHAEL. Well, I think it is and it is even a more difficult problem in the rural areas since access to family planning centers is more difficult. Access to maternal and child health care is more difficult. I guess we were talking about schools. The school boards in rural schools tend to be more conservative. They tend to be less likely to allow health educators into the classes in the middle

schools where they need to hear the same message that they hear in the urban schools. So, it may have come to Iowa and other rural areas later, but it is there nevertheless.

Senator HARKIN. Would you all agree with Ms. Elders' contention that this type of education should start early like maybe even kindergarten?

Ms. GARTH. Well, it depends on what type of education you are talking about. Now, see, the thing is in opening up, I mentioned abstinence has a variety of definitions that people have tagged along with it. I believe, yes, that kids need to learn self-control, discipline, the delay of——

Senator HARKIN. I think that is what Ms. Elders was talking about, a variety of different teaching things.

Ms. GARTH. That may be a part of it, but as far as the majority, I do not know. You might have to question her further on that. But as far as the substance of the things that we just talked about, the things that shape and mold a person's decisionmaking, yes, it should start at kindergarten. Whether sex education needs to start at kindergarten is another question. They are barely getting right is this a boy or is this a girl, and at that age they really do not care as long as they have someone to play with.

Mr. GREEN. I think the real key here, if I might, is that when you talk about sex education or you talk about dealing with condoms and so forth and so on, that type of thing should be very much a secondary issue. I do not want anybody coming to my 7-year-old talking about condoms and what that is all about. If that was a situation, then we can deal with that at that point, but in terms of just coming right out and she goes into a class and they start to discuss all those issues, then as far as I am concerned, I do not want to pay my tax dollars for that.

Senator HARKIN. But now, you are teaching your children obviously all the things about discipline and self-respect, and I assume also sex education as a parent.

Mr. GREEN. As a parent myself?

Senator HARKIN. Yes.

Mr. GREEN. We talk about everything but we do not talk about different ways that you can have sex. We do not talk about different ways to get around getting AIDS or whatever like some of what I have heard Ms. Elders say.

Ms. GARTH. Whenever you hear abstinence, you have to ask what is your definition of abstinence because I have been in rooms where many of us sit around and we talk abstinence. We all agree abstinence is the best way, but a lot of times I have been in classrooms where it was told to 10th graders you know you can do other things in the realm of abstinence. You can take showers together. You can engage in all these lists of things. Adults do not stop there. How is it that junior high school kids are going to stop there? And it all falls under the definition of abstinence, anything other than the physical intercourse of penetration. Everything besides that some people list under the definition of abstinence. So, they will agree with you and say I agree. Abstinence is the best thing that we can do because there will not be a pregnancy if there is no penetration, but you cannot go as close to the yellow line as possible and not get hit one day.

Dr. HOWARD. One of my favorite jokes is about the two preschoolers who are talking and one says, my dad found a condom on the patio last night. The other one says, what is a patio? [Laughter.]

Senator HARKIN. I did not hear that.

Dr. HOWARD. The other one says, what is a patio?

But the whole point is young people today are exposed to information about condoms. It is on the media about all these things. What we need to do is give young people information in age and developmentally appropriate ways but have them understand how to meet their needs for curiosity because kids are curious about sex. They are so bombarded by the media that they have all kinds of issues and their friends talk. So, what they need to do is to learn that there are ways to satisfy their curiosity without experimenting with sex. Very early on, even in elementary schools, we need to start giving them skills to resist those pressures from the media to experiment or from their friends to experiment. So, there are things we can do at all the different ages that will meet their needs and help them greet awakening sexuality with the same healthy curiosity we expect of them in other areas, but understand that that is a behavior you can manage.

Senator HARKIN. Thank you all very much. Thank you all for being here. I appreciate it very much.

Dr. HOWARD. Thank you for holding this hearing.

Senator SPECTER. I join the chairman in thanking you. Your testimony has been very worthwhile. Thank you.

Senator HARKIN. I just want to say again, Mr. Green, I appreciate your leadership in this area. As a sports figure, you send strong messages to young people, especially to young African Americans. Having you here and testifying and talking about what you are doing with young people, I tell you it makes up a lot for that other sports figure that said he had 14,000 partners or something like that.

Senator SPECTER. Almost 20,000.

Senator HARKIN. That just sends the wrong signal and you are sending the right signal. I appreciate it.

Senator SPECTER. Mr. Green, you did not have to play against any Iowa teams like you did against Pittsburgh and Philadelphia.

Senator HARKIN. No; he was lucky. He did not have to play against Iowa. [Laughter.]

Senator SPECTER. I join Senator Harkin in what he says. There are millions of youngsters who understandably idolize athletes, not Senators but athletes, so that what you say has great resonance.

Mr. GREEN. Well, let me just say, concerning this group of people, I am obviously the least of them up here, but what I try to do is try to live it, try to work hard at what I do. I do not consider myself the greatest speaker or whatever, but if you go over there to Franklin Street and you see some young kids and ask them about me, we are making a real difference with the people. And that is what it is all about.

Senator HARKIN. That is what it is all about. I wish we had more of you. Thank you. Thank you very much, Ms. Garth.

STATEMENT OF KARLETHIA JONES, STUDENT, DOUGLASS HIGH SCHOOL, ATLANTA, GA

Senator HARKIN. We have our third panel here, a group of young women. We have Karlethia Jones, a senior at Douglass High School in the Atlanta public schools. Come on up to the table. Karlethia has been a team leader for the Postponing Sexual Involvement Program for the past 2 years.

We have Ms. Colleen Morgan, 17 years old, who attends Lincoln Alternative High School, Clinton, IA. Colleen was 15 when her son Wesley was born. Colleen and her son live with her mom, stepdad, and sister in Clinton, IA.

Then we have Ms. Angela Renee McCoy who is 17 years old, also attends Lincoln Alternative High School. Angela is the mother of 15-month old Fabian and was 16 years old when her son was born. Angela and her son live alone in an apartment in Clinton, IA.

We welcome you here. You have heard the adults. Now let us hear from you. Your prepared statements will be made a part of the record, and I would just say just tell us what is on your mind. We will start with you, Karlethia, and thank you very much for being here.

Ms. JONES. Thank you.

When I was asked to speak on why I feel teens can help other teens postpone sexual involvement, I felt privileged because I was going to have the opportunity to talk about why I feel I have a significant effect on teenagers. I also had an opportunity or I have the opportunity, rather, now to tell why I am able to receive help from these other teenagers, as well as give educational help to them through this program, postponing sexual involvement.

I feel the program contributed and still contributes to the foundation on which I base my sexual decisions and, therefore, it is very important. I can still remember the first time when I was introduced to the postponing sexual involvement series. I was an eighth grade student at Silver Middle School in Atlanta, GA, and my health teacher informed us that someone would be coming to talk to us about how we could deal with the pressure of becoming sexually involved.

Now, being that the pressure to become sexually involved was really intense at this time in my life, I was very interested, but I was very skeptical also about talking to adults about my feelings about sex because most of the adults that were talking to us had not been my age for at least 10 years and in some cases many more years than that. When they were between the ages of 13 and 14, it was considered shameful to even admit that you thought about having sex. Now, they were actually feeling bad about having sex at that time in their life and their parents made sure that they did not have sex or that it was taken care of.

Now, here I was living in a time wherein teens were not only saying yes to sex but becoming sexually involved and pregnant before they could even spell the word "pregnancy." So, I did not really think that adults thoroughly understood where I was coming from or I did not think that they could help me really.

Therefore, I planned to sit in the back of the classroom next to the door so that when the class was over, I could get up and leave before my teacher had a chance to ask me why I did not become

involved in the program that they were going to be having on that day.

So, here we are. It is the first day of the seminar, and I was taking my time about getting to class because I wanted to make sure that all the seats at least on the first five rows were filled so that I would be near the door. Now, when I got to the door, to my surprise there was a young man sitting there who had a very beautiful smile and he greeted me very warmly. I shyly asked him if this is where the classes were meeting, and he said yes. I saw a young lady who was standing across the room who said that she would be helping also. So, I felt like right then at that point there was going to be some ease and comfort in that because there were people there that were closer to my own age, and I was convinced that he liked me a little bit, so I decided that I would sit a little bit closer to the front and maybe even ask a question or two.

Now that I am a few years older, I am a teen leader myself with the Grady Teen Services Program and I am trying to do for others what was done for me. My belief about teens teaching teens is fairly substantiated because of the fact that I have been walking around local malls in my area, and someone will come up to me and say, hey, do I not know you? Your name is Karlethia, right, or Karletha, which it is Karlethia. They will say I remember you because you taught one of my classes, or I think you go to Douglass High School, do you not? And I will say yes. It makes me feel as though I am really having a profound effect on them because they remember something that I have said. A lot of times they remember some of the techniques that we teach them, which is to say no. A lot of times they come up to me and say just say no and keep repeating it, and that is one of our assertive techniques. It makes me feel good to know that I have that type of effect on someone.

However, the Postponing Sexual Involvement Program has been not only beneficial to the teens that we teach, but it is beneficial to the teen leaders as well because it gives us an opportunity to remember what it was like to be an eighth grade student. Although we are only 2 to 4 years older than they are, our pressures are more intense or maybe in some cases have become a little bit more lax to become sexually involved. So, it helps us to remember how it feels to be exactly that age, the eighth grade age, and how we can relate to those problems and those concerns that they are having. So, it helps us to deal with how you say no, as well as helping them.

It gives us a chance to state our opinion and our beliefs, and so when our opinions are stated to those students, it helps them to feel that someone of their age group understands exactly what is going on and knows exactly what should be said and how you should deal with that problem.

Now, the last point that I would like to make focuses around the effect that the Postponing Sexual Involvement Program has had on my life. I can truthfully say that along with guidance from my parents and the postponing sexual involvement series, I have been able to deal with the pressures of having sex. I know that it is OK for me to say no without having to worry about feeling uncomfortable with that decision. Therefore, I am grateful to the program.

I would like to conclude by thanking the teens who took the time to teach me, as well as the Grady Teen Services Program and that Atlanta public schools whose cooperation helped us to enable students to take part in the postponing sexual involvement series because teaching teens does really work.

Senator HARKIN. Karlethia, thank you very much for your very excellent testimony.

STATEMENT OF ANGELA RENEE McCOY, STUDENT, CLINTON, IA

Senator HARKIN. Now we will turn to Angela Renee McCoy. Angela, welcome.

Ms. MCCOY. Hello. My name is Angela McCoy. I am 17 years old and my child Fabian is 15 months old. I was 15 when I got pregnant and 16 years old when I had my son. I am currently attending Lincoln Alternative High School in Clinton, IA.

Sometimes I feel it is hard to stay in school especially when the baby is sick or I am sick, but I feel I need to better my education more than ever now. It is not just for myself, it is for my son and I. I never have dropped out of school, but I had to consider it because I was running out of places for somebody to watch my son. Now the school day care watches him.

The programs that have helped me as a teen parent are Lincoln Alternative High School and the Young Moms Program, ADC and food stamps also. The program that has helped me the most is Lincoln Alternative High School. They gave me a chance to finish my high school education. They provide me a day care center right by the school. We as moms work in the day care one class hour a day for payment to keep our children there. It has helped me stay in school and further my education. The teachers and the students at Lincoln are more supportive. Nobody really looks down on you. The faculty is always there to help you with your problems if you need it.

Another group that has helped me is Young Moms. In Young Moms we can talk openly with our group of other peers who have the same situation that I do. We can talk about our problems, happy things, sad things, basically anything we need to. We always have a topic to talk about after our sharing time is over. Our topics have ranged from child abuse, birth control, child support recovery, stress and much, much more.

I think that teen pregnancies can be reduced by providing more programs where teen moms go to schools to talk to the younger generation. We need to provide better sex education to our young people. Do not tell them sex is wrong, just show them the facts and let them know what does happen. Let them know that the babies are cute and lovable, but also the biggest responsibility they could ever have.

To help teen moms I feel we need a lot more support groups to get them through the stress so there are fewer kids abused and neglected. Let them know that they are not the only ones in this situation and there is something that they can do.

I think we need to get teen dads more involved in their kids. Give them support groups to help them deal with the stress of knowing they are going to have a little one running around or they already do. I would also like for teen dads to accept more respon-

sibility and take part in their child's life. They need to be told it is OK to have a child. It is not just the mother's fault. It takes two people to make a baby.

Teens also need to be more informed that no birth control is 100 percent effective besides abstinence. Let them know that pregnancy is just the beginning and about sexually transmitted diseases, emotional problems, and stress.

PREPARED STATEMENT

I also think that most teens overlook adoption. We need to stress to pregnant teens that if you feel you cannot take care of your baby, it is all right to give her or him up for adoption. People need to understand it is not because you do not love your child, it is because you do love them and want them to have the best you can give your son or daughter. Most people do not see it that way. They feel it is a bad thing.

That is all.

Senator HARKIN. Well, Angela, thank you very much. You are very brave to be here and I appreciate your coming all the way from Clinton to be here today.

[The statement follows:]

STATEMENT OF ANGELA MCCOY

My name is Angela McCoy. I am 17 years old, and my child, Fabian, is 15 months old. I was 15 years old when I got pregnant and 16 years old when I had my son. I am currently attending school at Lincoln Alternative High School in Clinton, Iowa.

Sometimes I feel it's hard to stay in school especially when the baby is sick or I am sick, but I feel I need to better my education more than ever. It's not just for myself, it's for us (my son and I). I have never dropped out of school but had to consider it. While I'm in school the school's day care watches my son.

The programs that have helped me as a teen parent are the Lincoln Alternative High School and the Young Moms program. The program that has helped me the most is Lincoln Alternative High School. They gave me a chance to finish my high school education. They provide a day care center right by the school. We as moms work one class hour a day in the day care as payment for using this service. It has helped me stay in school and further my education. The teachers and students at Lincoln are more supportive. Nobody looks down on anybody for anything.

Another group that has helped me a lot is Young Moms. In Young Moms we can talk openly with a group of other peers who are in the same situation we are. We can talk about problems, happy things, sad things, basically anything. We always have a topic to talk about after our sharing time is over. Our topics have ranged from child abuse, birth control, child support recovery, stress, and much, much more.

I think that teen pregnancies can be reduced by providing more programs where teen moms go to schools. We need to provide better education of sex to our young people. Don't tell them sex is wrong, just show them the facts and let them know what can and usually does happen. Let them know babies are cute and lovable but also the biggest responsibility they could ever have.

To help teen moms I feel we need a lot more support groups to help them get through the stress so there are fewer kids abused and neglected. Let them know, that they are not the only ones in this situation.

I think that we need to get teen dads more involved in their kids. Give them support groups to help them deal with the stress of knowing they are going to have or already have a little one running around. I would also like for teen dads to accept more responsibility and take part in their child's life. They need to be told it's okay to have a child that it's not just the mother's fault. It takes two people to make a baby and the fathers were part of it.

Teens also need to be informed that there is no birth control that is 100 percent effective besides abstinence. Let them know that pregnancy is just the beginning and about sexually transmitted diseases, emotional problems and stress.

I also think that most teens overlook adoption. We need to stress to the pregnant teens that if you feel you can't take care of your baby it is all right to give him or her up for adoption. People need to understand it's not because you don't love your child. It's because you do love them and want them to have the best that you give your son or daughter up for adoption. Most people don't see it that way.

I basically feel that if society doesn't accept that pregnancy is going to happen and try to help, then there isn't much more we can do to solve the problems of teen pregnancy.

STATEMENT OF COLLEEN MORGAN, STUDENT, CLINTON, IA

Senator HARKIN. Now Ms. Colleen Morgan.

Ms. MORGAN. My name is Colleen Morgan and I am 17 years old and my son Wesley is 2. I became pregnant when I was 15 in my sophomore year of high school. I could have quit when I found out I was pregnant and just forgot, but I stuck it out. I was out of school for 2½ months, and I could have quit then. But I had one class that I could get credit in, so I stayed. My stepdad watched my son for me because I had no other person to watch him.

The programs that have helped me the most are Lincoln Alternative High School and the day care, Young Moms, and the WIC Program.

I think Lincoln Alternative High School has helped me the most with the day care and being able to work out my schedule where I can come to school at a time when I think I can get up and get ready and be there every day instead of 8 a.m., like most high schools. If Lincoln did not have the day care, I know I would not be in school at all. Also, at Lincoln all the teachers are really understanding if there are problems with our kids and stuff and they give us a lot of support.

Young Moms has helped me a lot because I get support and information from people who are going through what I am or else they have already gone through it and they can give me advice. I think there should be a lot more Young Moms groups around the country because I know they have helped me deal with a lot of things and not just to do with me and my child, like my home life and relationships and stress. We also talk about discipline and fun things to do with our children and nutrition, but it is just really supportive and nobody puts anybody down for anything.

WIC has helped me. It has been a big help because like with formula when my son was little and other food that I cannot get without it because we did not have enough money. I do live with my parents and my sister. You cannot really feed four people and buy formula on what little food stamps you get. I do not think my son probably would have had what he would have needed without WIC.

I really do not think ADC is working for teen moms because you have to be 18 to get it unless you go through a lot of paperwork. If you are still living with your parents, they go by their income. If you want to save money to try to get out on your own, you cannot—you know, trying to get a check or two to save up to pay the rent to pay the bills. Nowadays you cannot even get an apartment without being 18. If your parents kick you out and want nothing to do with you, what do you do?

PREPARED STATEMENT

I think teen pregnancies can be reduced more by education at younger ages. In Clinton a group of our teen moms go out and vol-

unteer our time and talk to younger students about what it is like to be a teen mom. I think the students listen to us a lot more than what they do the teachers because we are their peers. I know if I would have had that when I was younger in sixth or seventh grade, I probably would have thought twice about becoming sexually active. I probably would have listened to them more.

[The statement follows:]

STATEMENT OF COLLEEN MORGAN

My name is Colleen Morgan and I am 17 years old with a 2 year old son. I became pregnant when I was 15 years old which was my sophomore year of high school. Due to my pregnancy I was out for 2 and a half months at the end of that school year. I could've quit then, till the next year but I wanted to get what little credits I still could so I went back to my high school for 1 class a day and couldn't have done that without my step-dad watching my son.

The programs that have helped me the most are Lincoln Alternative High School and day care, Young Moms, and W.I.C. (Women, Infant, and Children).

I think Lincoln Alternative High School has helped me the most with the day care and being able to work out my schedule where I can come to school at a time in the morning when I think I can make it every day instead of 8 a.m. like most high schools. If Lincoln didn't have the day care I wouldn't be in school at all. Also at Lincoln all the teachers are understanding and give us a lot of support when something goes wrong.

Young Moms has helped a lot because I can get support and information from people who are going through what I am or they have already gone through it and can give me advice. I think there should be more Young Moms groups around the country. I know they've helped me deal with a lot of things and not all to do with my child; like home life, relationships, and stress to name a few. We also talk about discipline, fun things to do with our children and nutrition.

W.I.C. has been a big help with formula for my son and other food that I could not have gotten without them. I do live with my parents and my sister. Trying to feed four people and buy formula just doesn't work. My son probably wouldn't have had as much formula as he should have had without W.I.C.

I personally don't think A.D.C. is working for teen moms. For one, you have to be 18 to get it unless you go through a lot of paper work. Also if you are still living with your parents they go by their income and maybe you want to save money to get out on your own but can't without the first check or two to pay for rent and hook-ups and other bills. But you can't even get an apartment without being 18. What if your parents kicked you out and want nothing to do with you? Where do you go?

I think teen pregnancies can be reduced by more education at younger ages. In Clinton a group of teen moms from Lincoln Alternative High School volunteer our time to go and talk to younger students about what it's like to be teen mom. I think the students listen to us a lot better than the teachers because we are their peers. If I would of had that when I was in 6th or 7th grade I probably would've thought twice about becoming sexually active.

Senator HARKIN. Colleen, thank you very much. I appreciate it. As I said, all three of you are very brave for being here and telling us your stories. We need this kind of information in order to make decisions here, so I do appreciate your being here very much, all of you.

It seems like all three of you are involved in some kind of teen program of outreach to other teens, both of you from Clinton and you, Karlethia, in Atlanta. You are involved in this teen program of teaching other teens. Right?

Ms. JONES. Correct.

Senator HARKIN. Karlethia, in your program—what is it called?

Ms. JONES. It is called the Postponing Sexual Involvement Program.

Senator HARKIN. Postponing Sexual Involvement Program. I can only assume that there must be some kids in your school there who

are parents like either Colleen or Angela. Are they involved in these programs too?

Ms. JONES. Yes; they are. Most of the time I do not get too many classes wherein somebody is pregnant or has had a child, but there have been cases when there are students that have already had children who are there or some students that are pregnant at the present time. What we try to stress to them then is that, OK, you have had a child or you are having a child now, but it is OK now for you to turn around and say I will abstain from this point on so that you will not have any more children.

Senator HARKIN. I agree that teens reaching out to other teens can be the best and most effective teaching methodology if the message is right and if you have people there who can really talk about their experiences.

Both Angela and Colleen, you are involved in—what is it called? Teen Moms Program?

Senator HARKIN. Young Moms Program, and you talk to other teenagers. Right?

Ms. MCCOY. Yes.

Ms. MORGAN. Yes.

Senator HARKIN. What are the questions that these younger girls are asking? What do they ask you? What is the first thing they want to ask you about?

Ms. MCCOY. Does it hurt when you go into labor?

Senator HARKIN. See, practical stuff.

Ms. MCCOY. That is usually the first question.

Senator HARKIN. That is right. I can understand that, sure.

Anything else beyond that?

Ms. MCCOY. Usually they ask where are the fathers, are the fathers still around, questions like that. How are you financially capable of taking care of a child?

Senator HARKIN. Let me get this clear. Are you just dealing with other teenagers who are pregnant?

Ms. MCCOY. Young moms is an outside-of-school activity that we go to on Fridays, but we volunteer—Colleen and I do anyway—our time during school or when they ask us to go to like the middle schools in the community and outside of the community and tell them about our experiences and try to convince them to abstain from having sex.

Senator HARKIN. Are young boys involved in this program?

Ms. MCCOY. No; I do not know why.

Senator HARKIN. Mrs. Machael, how come? Come on up to the table. Why are not young boys involved in this?

Ms. MCCOY. I asked the same question.

Ms. MACHAEL. I agree. We have talked in our agency about that. We have a male health educator and he says, boy, I would like to have a teen dads program, but I do not know if we would be able to find teen dads who would come and join the program. As a matter of fact, somebody even said could we bring a teen dad with us here today, and having young dads come forth and identify themselves as teen fathers is a little more difficult than for teen mothers who it is obvious that they are pregnant.

Senator HARKIN. Let me clear up what I am thinking here. Now, this teen moms program, are you involving young teenage girls who have not become mothers yet?

Ms. MCCOY. That are pregnant?

Senator HARKIN. Well, that either are pregnant or—no. Just other girls, just young girls.

Ms. MACHAEL. Pregnant and parenting teens only.

Senator HARKIN. Pregnant and parenting teens only.

Ms. MACHAEL. It lasts for 2 years. It is to help them get through what we consider to be the most difficult time in their life when they are likely to drop out of school, they are likely to get pregnant again, et cetera.

Senator HARKIN. Right.

Karlethia, in your program you involve young boys, right?

Ms. JONES. Yes; we do.

Senator HARKIN. It is mixed, male and female.

Ms. JONES. It is mixed. As a matter of fact, we not only tell them to just say no, but we have assertive techniques and we also have demonstrations wherein we have practical situations wherein it may be a situation that they may encounter on a daily basis and it shows them how to interact with that person if the situation should arise.

Senator HARKIN. Thank you. I might come back to this a little bit, but I want let Senator Specter ask questions.

Senator SPECTER. Thank you very much, Mr. Chairman, and I thank you young women for coming in today.

The question that I have starting with you, Ms. McCoy, is the one where you say—and I am in no way disagreeing with you, but I want to find out what your thinking is where in your statement you said, referring to teenagers, "Don't tell them sex is wrong, just show them the facts and let them know what can and usually does happen." Then a little farther down in your statement you talk about the need to get teen dads more involved in the program and you say, "They need to be told it's OK to have a child and that it's not just the mother's fault."

Ms. MCCOY. If you tell somebody that is in sixth or seventh, even eighth grade, sex is wrong, morally sex is wrong, well, sex is not morally wrong. You have to have sex to reproduce. Don't tell them sex is wrong. Just tell them what can happen if you have sex at too young of an age. Explain what can happen because if you tell them it is wrong, they are going to do it. If somebody would have come up to me and said it is wrong—like my parents—your parents come up and say it is wrong, do not do it, you are always going to experiment and try and do what they tell you not to, always.

What was the other question?

Senator SPECTER. No; that is the same question. The same question is how you approach that issue.

Let me ask you about questions which some people have asked you. You said they ask you about the father, and one of the items that Senator Harkin is trying to take leadership on is to have fathers bear financial responsibility. You raise a very good point here about having fathers involved in bringing up the child to have an emotional responsibility as well as a financial responsibility. Without prying into your own situation to any extent beyond what you

want to tell us about, I would be interested in your views as to how you get the fathers involved both emotionally and financially because it is obviously a very difficult situation.

Ms. McCoy. They always have to give a name when you go down to apply for ADC or whatever. If they would just get a hold of the father instead of just going through child support recovery, call the father, with you sitting there, and ask them are they going to take any part in this. They always go after them for financial responsibility.

Senator Specter. Did they go after the father for financial responsibility in your situation?

Ms. McCoy. Yes; they did.

Senator Specter. Were they successful?

Ms. McCoy. No; they were not because he was on SSI and they cannot take out of his check to give to mine.

Senator Specter. Do you think it would be a good idea that Senator Harkin is proposing to have a deduction from whatever income the father receives?

Ms. McCoy. Yes. [Laughter.]

That is just my opinion, but yes.

Senator Specter. Well, your opinion has a lot of weight. You have been there.

What about an emotional involvement or participation?

Ms. McCoy. I think that no matter what, every child needs a father. I do not know how to say it. My son will see his father. I think that you should arrange times.

Senator Specter. Your son will see his father?

Ms. McCoy. He does see his father.

Senator Specter. How old is your boy?

Ms. McCoy. He is 15 months old.

Senator Specter. How often does the father see the son?

Ms. McCoy. At least once a week.

Senator Specter. Well, good for you, good for the father.

Ms. McCoy. We need to set up times and days. If you do not want to be there when your child is seeing the father, so be it, but I think it should be expected.

Senator Specter. How do you feel about that?

Ms. McCoy. Right now? I do not want to be there when he sees his father, but I will be just for the simple fact that I do not trust him. I will go through that just because I do not feel it is right for him not to have a father.

Senator Specter. How old is the father?

Ms. McCoy. Almost 30. So, he is not a teen dad.

Senator Specter. Does the father work, have income?

Ms. McCoy. He is on SSI. It is disability. I am not exactly sure what.

Senator Specter. With a father that old, was there any consideration to holding him criminally responsible?

Ms. McCoy. No; because in the situation when we met, we both lied about how old we were. My father wanted to hold him criminally responsible, but it did not happen.

Senator Specter. Karlethia, how do you feel about what Angela has said about not telling teenagers that sex is wrong? What do you think about that?

Ms. JONES. I feel that you should not say, as she said, that sex is wrong because sex is not wrong. It is having sex when you are not ready to take care of the consequences that come along with it that is wrong. So, I advocate stressing to teenagers that they can put it off, delay having sex before you are ready to take care of the responsibility because there are several adults who are not ready to take care of those responsibilities. So, it is important that you wait until you are able to take care of what needs to be taken care of.

Senator SPECTER. Well, your views are very important because you are young and you understand the current reaction a great deal more than those of us who are not in your age categories. Times change and responses change, and it is a different world than when Senator Harkin and I were in our teens. There is a lot of talk among the older people about stressing moral values and about saying that sex for teenagers is wrong. Maybe it is a matter of how we articulate it or maybe it is more a fundamental matter as to how we look at it. We want to try to be sensitive and understand your perspective both to understand the perspectives of teenagers and also to say and do things which are effective.

Karlethia, would you say that when the President or when a Senator makes a speech and tries to talk about moral values and saying that premarital sex is wrong or sex for teenagers is wrong, that that is a bad approach and there should be a different way that it is said?

Ms. JONES. I would not say that is a bad approach, but I would say that it does not reach many teenage students or teenagers period because of the fact that a lot of the times, teenagers do not listen to the TV when the President is speaking or Senators are speaking because that is not something that is appealing to them.

But when a student or someone among their own age group comes to them and says really that is not something that you have to do, then they will listen to that a lot more readily than if someone of an adult stature were to come to them and say, hey, do not have sex because when a teenager thinks about it, they say, well, he is old or she is old. They have already done it anyway, so it is probably no big deal to them now. So, they really do not listen to that.

It helps a lot more if you have someone that is going through the exact, same thing in the same time, not 10 years ago or 15 years ago, but who are going through it now like you are and they understand the same pressures that you are going through. They understand the lines that are coming on now, and they understand the messages that the media are placing upon you. It helps a lot more when the teens teach the teens.

Senator SPECTER. So, it is important as to who the messenger is and what the message is.

Ms. JONES. Right.

Senator SPECTER. But you would agree with Angela when she says, "Don't tell them sex is wrong, just show them the facts and let them know what can and usually does happen."

Ms. JONES. Correct.

Senator SPECTER. Colleen, I would like to know how you feel about that. I was very interested in your statement that you think

that if you had had information when you were in the sixth or seventh grade, you would probably have thought twice about becoming sexually active. What kind of information do you think that had you had it in the sixth or seventh grade would have stopped you from becoming sexually active?

Ms. MORGAN. Well, like the groups that we have now or like me and Angie will go to schools, usually junior high, and we talk to them about what it is like to be a teen parent and we tell them the negatives. We do tell them some of the positives, but we mostly steer them toward not becoming pregnant, not having sex.

Senator SPECTER. What negatives do you tell them about?

Ms. MORGAN. Well, you do not have all the money that you think you are going to have. You hardly have enough money to live on, to have an apartment, to pay the bills, or stuff that you need.

Senator SPECTER. Do you have an apartment?

Ms. MORGAN. I live with my mom and dad.

Senator SPECTER. You live with your parents.

Ms. MORGAN. But like in Angie's case, Angie runs out of money before like the third day of the month.

Senator SPECTER. Angie, do you live by yourself?

Ms. MCCOY. Yes; I do. I live just with my son and I in a one-bedroom apartment.

Senator SPECTER. Where do you get the money?

Ms. MCCOY. I am on ADC right at the moment. I do not enjoy it. I do not want to be on it.

Senator SPECTER. You are on AFDC.

Ms. MCCOY. Yes; I do not want to be on it but until I can finish high school and get a job, I do not enjoy living off of it.

Senator SPECTER. There has been a good bit of talk—and you have heard it here today—that if AFDC or other Federal programs were not available, that that would discourage teenage pregnancy. I would be interested in your views about that. What do you think, Angela?

Ms. MCCOY. I do not know if it would discourage teenage pregnancies because I do not know anybody that would want to get pregnant to get money. I just cannot see it happening. I know there are people that do it, but I know I would not and I know a lot of people that would not.

The Norplant thing. This really bothered me. I will not get surgery. I get a Depo shot every 3 months. It is a birth control shot. I would rather have that. I think we should have a choice. I think after your first child you should get some kind of form of birth control that is going to be effective in order to receive your check every month. I think that is a necessity.

Senator HARKIN. Really now. You made me sit up straight there on that one. [Laughter.]

Ms. MCCOY. I think that way there are not reoccurring pregnancies and we are not spending more money than we really need to.

Senator HARKIN. Let me just understand what you just said there. You said that you feel—you correct me if I am wrong.

Ms. MCCOY. OK.

Senator HARKIN. You said you feel that for a young person who has one child that there ought to be some form of birth control

made available to them, and did you also say that it ought to be contingent on their receiving ADC?

Ms. MCCOY. Yes; I think it should be.

Senator HARKIN. So, you disagree a little bit with Ms. Elders on that. She did not think that.

Ms. MCCOY. I think it is necessary. There are too many reoccurring teen pregnancies after the first one. Well, hey, I can have another one. They are not ready for it. I know right now if I had another child, I would be crazy. So, I think in order to get your check every month, you should have at least a sturdy form of birth control. That is just my opinion.

Senator HARKIN. I guess what you are saying is it does not necessarily have to be Norplant. It could be something else.

Ms. MCCOY. Yes; I will not let them do surgery.

Senator HARKIN. Do what?

Ms. MCCOY. The Norplant is a minor surgery and they put it in your arm. There is no way.

Senator HARKIN. But Depo Provera is——

Ms. MCCOY. It is a shot.

Senator HARKIN. It is a shot.

Ms. MCCOY. So, I can deal with that, but I cannot deal with surgery.

Senator HARKIN. How do you feel about that? Do you mind if I interject here? This is interesting.

Senator SPECTER. That is fine.

Senator HARKIN. How do you feel about that, Colleen?

Ms. MORGAN. I agree with Angie, but also if they still need to go to high school, I think that also to get their check, they should finish their high schooling and provide high schools with day cares so they can finish their high school and better themselves because I think a lot of teen moms would because I know a lot of teen moms that do want to finish school and there are not enough schools with day cares.

Senator HARKIN. I am going to start asking more young people the question I asked Ms. Elders. Thank you very much.

Ms. JONES. If I may, can I address that question?

Senator HARKIN. Yes, please do.

Ms. JONES. I do not feel that it should be conditional that the female be made to have a birth control method in order to receive that program because of the fact that if she does not have any other way to turn, any other place to look toward, then if she does not want to take that birth control, then that slams the door in her face. However, I do very much advocate the fact that she should be made to complete high school and also go on to a trade program wherein she would be taught skills that will help her provide for that child and herself.

Senator SPECTER. As a condition to getting help from the Federal Government?

Ms. JONES. Right, correct.

Senator SPECTER. Well, suppose she does not do that. Then what do you do to support the child, if not the mother, or the mother too? You say there should be a requirement that she would have to complete school or a trade program in order to continue to get welfare payments, AFDC, but suppose she refuses to go to school or learn

a trade. Then how can you cut off the payment for the child's support or the mother's support?

That is a central question about when you set requirements up which makes sense, but somebody does not comply with them. Then you have the innocent child not supported and the young mother too.

Ms. JONES. That is true.

I do not really think that there are a lot of teenagers that would be dead set against completing school and going to maybe a 2-year trade school because a lot of the students that I teach and a lot of the people that I know that have become pregnant, the main concern for them is how am I going to remain in school so that I can be educated and one day provide for my child. That is one thing that is really important to those people that have become pregnant at an early age. So, I do not think that they will say no to that.

However, if they did and the child is left there, I think there should be programs set up to take care of those children because the mother really should take that responsibility since she has become pregnant to take care of that child, but if she does not, I think there should be other programs set up for that child wherein that child will be taken care of.

Senator SPECTER. Mr. Chairman, I am going to have to excuse myself. I think this has been really very worthwhile. It is now 12:10 p.m., and I think it has been a very informative hearing. I have time reserved on the Brown nomination, which is now pending on the floor. So, I am going to have to go there, but I want to thank you again, Mr. Chairman. I want to thank you all for coming.

We have tried to have inputs on this panel from the experts of all ages and perspectives. Perhaps the best experts are the three teenagers who are here today. I do believe that we have to listen to those of you who are really most intimately knowledgeable on the subject as we try to wrestle with these problems because we want to do the right thing, but it is hard to figure out just how to provide the motivation and what is the language which will be listened to. So, I thank you.

Senator HARKIN. Thank you, Senator Specter. I thank you again for getting the committee to hold this hearing. We are going to have one more I guess in June. Right?

Senator SPECTER. We decided that we just had too many important witnesses that we wanted to be sure to hear them because we do not like to rush through them. Even if you start earlier at 9:30 a.m., you are past noon and there comes a break point.

Senator HARKIN. We will do that.

I just have one other question. With all these TV cameras and stuff up there pointed at you, I want to ask you the question I asked earlier. As teenagers what role does the media have in encouraging young people to engage in sexual activities? I see you smiling, so I will just start right here with Angela and I will work our way across there.

Ms. MCCOY. I feel the media has a lot to do with it. High school not as much as middle schools. By the time I was in high school, I was mature enough to know the difference between TV and real life, but when you are in middle school, you think, wow, what hap-

pens on TV is how I want my life to be. If you see two people about to have sex, that is what you are going to want to do. I feel it has a big impact on young people.

Senator HARKIN. Karlethia.

Ms. JONES. I believe that the media has a substantial effect on the minds of students, teenagers, anybody really. I have younger brothers. One is 9 years old and one is 14. Everything that they think about or everything that they say or do is basically something that they have heard or seen on TV. It bothers me sometimes because they watch things that really should not be shown to children of that age. We do not even have cable, as a matter of fact. So, it is not that they are watching programs that my mother just would hate for them to watch. It is just that everything that comes on TV has some sexual message in it.

Also the music that we listen to. The music that is played on the radio has a lot of messages, subliminal as well as coming right out and saying you should have sex now. You should do it whenever you feel like it regardless of your age. A lot of times these kids are listening to the beats that are going along. They are not too much listening to the words, but now that the words are just so explicit and just right out there—and we do not listen to hard rap. A lot of people say that that is the issue, hard rap and all these types of songs which are really just vulgar. I do not listen to vulgar music. It may be just something that is slow and mellow, a mellow slow song that all teenagers that I know listen to, just a regular old song. It has words in it or it has messages in it that are not good for students to listen to or teenagers to listen to because they are just really influencing them to go on and have sex at an early age.

Not only are TV and movies and things of that nature, but what about the magazines that you flip through? In our program, before you become a team leader, you are asked to go through a training program wherein you have to sit down and go through the magazines that you just every day look at. What we have to do is pull out pictures that have subliminal messages in them.

I noticed that when I was going through the magazines, I had never really even thought about the messages that were there. I would just look and say, oh, that is a nice picture and that is cute. I would just do like that. But once I had the opportunity to sit there and really just look at what was there, they may be advertising perfume, but the biggest thing on the page is two people kissing. Why? Sometimes the perfume bottle is not even there. The name of the perfume may just be there. Jean advertisements. She may not even wear jeans or he may not even wear jeans. There are really a lot of messages that are given in those magazines and things of that nature. So, I say that the media has a very profound effect on what teenagers and other people think.

Senator HARKIN. Colleen.

Ms. MORGAN. I think the media does have a lot to do with what teenagers think because you come home and even on talk shows they talk about sex.

Senator HARKIN. That is all they talk about.

Ms. MORGAN. You just flip through the channels, even some cartoons get pretty—like Ren and Stimpy. A lot of kids like those. I

do not like them. Even if you go to watch a decent TV movie, there is sex in it. You cannot watch anything anymore without sex.

Ms. JONES. It has come to the point where you expect to see that and you feel like where was that in the movie, where was sex in the movie? If you see a movie that does not have it, it seems like there is not as much of a thrill in the movie. A lot of people do not even want to go and see a movie that does not have those messages in it because they are so used to seeing it and they think that is what makes a good movie.

Ms. MACHAEL. If I could add one really frightening addition to something Karlethia said a few minutes ago, it is about magazine advertising, and what we see is the pictures of sexuality in magazine ads, especially those directed at young women, are of 9-, 10-, 11-year-old women, preadolescent women, and older men. I think there is a really frightening trend in some of the ads that we see that are being mass marketed to young women.

Senator HARKIN. Maybe I am not reading these magazines.

Ms. MACHAEL. I will send you a packet of stuff. We have a social worker who goes around the community giving a slide presentation on this, and it is mind boggling. It is shocking. I will send you pictures.

Senator HARKIN. I probably ought to know about that. I do not know about that. I should know about that. That is frightening.

Well, listen, I guess at this time we will call this to a close. I appreciate very much your being here. I will say I think the best part of the whole day was listening to you, and I mean that. I think you have offered a lot here, and your testimony has been very valuable. You are all very thoughtful young people.

I wish you the best. You all seem to be getting in the right direction here, moving ahead. Keep on in that direction. I think you all three are going to be great successes in your life. I mean that. Just take your experiences and what you have been doing and help some other people out too. I know you are doing that and I encourage you to keep doing it too.

Ms. Machael, all of you, thank you very much for being here.

SUBCOMMITTEE RECESS

The subcommittee will now recess until 9:30 a.m., Wednesday, June 8 in room SD–192. At that time we will hear testimony from nondepartmental witnesses on teen pregnancy.

[Whereupon, at 12:18 p.m., Wednesday, May 25, the subcommittee was recessed, to reconvene at 9:30 a.m., Wednesday, June 8.]

TEENAGE PREGNANCY

WEDNESDAY, JUNE 8, 1994

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:35 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Arlen Specter presiding.

Present: Senators Specter, Stevens, and Gorton.

NONDEPARTMENTAL WITNESSES

STATEMENT OF HON. ESTHER SYLVESTER, CHIEF ADMINISTRATIVE JUDGE, FAMILY COURT DIVISION, CITY OF PHILADELPHIA

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. The hearing of the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies will now begin.

This is the second in a series of hearings on the issues relating to teenage pregnancy. We had the first hearing on October 25 and heard at that time from Surgeon General Dr. Jocelyn Elders and a panel of distinguished witnesses, including a number of teenagers, who provided some really remarkable insights into this issue.

Senator Moynihan, who has been the national leader on this subject for many years, has suggested that this may be the most important problem facing our society today, as it cuts across and impacts on the family structure, on educational opportunities, on creating difficulties in finding and holding jobs, on crime control, and on a whole range of very significant societal problems. We are taking up the subject in this subcommittee with a view to funding a good many programs which would impact on this issue.

We have a very distinguished group of witnesses today. As I say, the original hearing sought to include all those who are here today. And before calling on our first witness, I would like to yield to my distinguished colleague, Senator Ted Stevens.

Senator STEVENS. Thank you very much, Senator Specter.

I am sorry to say, once again, I have another meeting at 10 o'clock. But I commend you for continuing these hearings. As I said at the first hearing, this is a substantial issue in Alaska, and I am most interested in the outcome of these hearings. Thank you. It is nice to be with you.

PREPARED STATEMENT

Senator SPECTER. Thank you very much, Senator Stevens.

In the interest of time I will now insert my opening statement into the record.

[The statement follows:]

STATEMENT OF SENATOR ARLEN SPECTER

This morning, the Subcommittee on Labor, Health and Human Services and Education will continue the teen pregnancy hearing which began on May 25, 1994. During the last hearing, we heard from Surgeon General Elders, health professionals, program directors and teens. Today, we will receive testimony from another group of professionals and teens who will give us their unique perspectives on how they are addressing the adolescent pregnancy issue.

When one talks of social ills in America today, the problem of increasing numbers in births to adolescents is always at the top of the list. As is shown on chart 1—between 1986 and 1991, the rate of births to teens aged 15–19 rose 11.9 percent, from 50.2 percent to 62.1 births per 1,000 females. This increase occurred among both younger and older teens and holds for all ethnic groups and all regions of the country.

It is also worth noting that the teen pregnancy rate in the United States tops that of all other developed countries, despite the fact that those countries have similar rates of sexual activity. The U.S. teen birth rate is more than double the rate of teens aged 15–19 in Canada and Australia. France and Japan report the lowest rates of teen births with 9 and 4 births per 1,000 respectively, in the 15–19 age bracket (chart 2). Charts 3 and 4 demonstrate the dramatic increase in births to unmarried females since 1980, with unmarried birth rates rising 21 percent over that time period.

We must find programs to address the teen pregnancy problem as is indicated by the rising costs associated with teen births. In 1990, an estimated 51 percent of Aid to Families with Dependent Children payments went to recipients who were 19 or younger when they first became mothers. Based on estimates of AFDC, Medicaid, and Food Stamps, support to families begun by a teen birth cost the U.S. over $25 billion in 1990, up $3.5 billion from 1989. It is estimated that if every teen birth had been delayed until the mother was in her 20's, the U.S would have saved 40 percent of these expenditures, or $10.2 billion.

The report released yesterday by the Alan Guttmacher Institute points out that one-fifth of teens are virgins at 19 years of age and that two-thirds of teens are trying to act responsibly by using some form of birth control. However, the report also points out that while birth control has cut pregnancy rates among sexual active teen, the sheer numbers of teens having sex means that overall pregnancy rates have increased, not declined.

I look forward to hearing your testimony and discussing your ideas on how the problem can best be addressed.

In order to assure that we will have adequate time for questions and answers, we ask that the professionals who are testifying today limit their testimony to five minutes, and the teens have been allotted three minutes for their opening remarks. The Committee has installed a series of lights to help us all adhere to that policy.

We are pleased to have as our first witness this morning, the Honorable Judge Esther Sylvester, Administrative Judge of Family Court Division, Court of Common Pleas of Philadelphia.

Judge Sylvester, we will be pleased to receive your testimony at this time.

SUMMARY STATEMENT OF HON. ESTHER SYLVESTER

Senator SPECTER. Our first witness will be a very distinguished jurist, Judge Esther Sylvester, who is the chief administrative judge of the Family Court Division of the City of Philadelphia.

Judge Sylvester has had a very successful career, starting in the private practice of law with the Beasley law firm, then taking a substantial cut in salary—the year I shall not mention—to join me in the district attorney's office as a trial lawyer, Ted, to go into public service. And this is something you understand well because you have done it yourself. It takes a lot of determination and a lot

of sacrifice financially, although I think the rewards are commensurate.

But Judge Sylvester now heads the family division of the city of Philadelphia, a very complex court with many responsibilities, a tremendous workload, and I know that Judge Sylvester has had special insights into the problem of teenage pregnancy.

We are delighted to have her here today. I know how complicated it was for her to arrange her schedule to be here because of very many pressing demands. We have a practice of asking that witnesses limit their opening statements to 5 minutes to allow for the maximum time for questions and answers, and there is some flexibility. So we would like you to proceed, Judge Sylvester.

Judge SYLVESTER. Thank you, Senator Specter, for the invitation. Senator Stevens, I hope that I am able to contribute something to this issue. I wish I could sit here and say to you that I have the solution. I do not.

But I do come here with years of experience on the juvenile side of the court. I began there in 1986 in juvenile court. I became the administrative judge in July 1992. Philadelphia Family Court is both juvenile court and domestic relations.

I was thinking, coming down here, about the judges who are assigned to juvenile court. There are nine of us. The seven in the middle have about 40 years experience dealing with juvenile problems. The youngest judge, who is there 4 years, has 23 years in the system because he was a probation officer and a juvenile master before he became judge.

And the oldest judge, I am sure Senator Specter knows, is Nicholas Cipriani, who is now a senior judge working full time there, who was the administrative judge. He has probably contributed 20 years of experience to what we bring here to you today. We have seen a lot of programs in Philadelphia, many of them through the court, and seeing which work and which do not work.

I will be the first to say, and you see from my paper, that 59 percent of the births in 1991 were children born to unwed mothers. Of that percent, 17 percent, or 5,000 births, were to children under 20 years of age. Now, we have got the problem. It is as real in Philadelphia as anywhere else.

My information comes from the Philadelphia Department of Public Health Vital Statistics Report for 1991. I just put in the page that I refer to, which was, I think, a horrendous figure. Senator Specter, if you would like me to leave a copy of this with you, I will. But it goes into much detail about which children across races are having children.

Senator SPECTER. Thank you very much, Judge Sylvester. We would be pleased to review it.

Judge SYLVESTER. All right. Thank you.

Philadelphia Family Court started an initiative with the University of Pennsylvania, Dr. David Metzger, on something called the problem severity index. It was a questionnaire designed with the help of the professors at the University of Pennsylvania to get at the family needs and the personal needs of these kids who are coming into the juvenile system.

We probably started it about 1 year ago. And we received the first set of data on these questionnaires. Dr. Metzger took question-

naires from Philadelphia County and then went out to suburban counties, and then went out to rural counties. As we look at the data, we are seeing that, of the delinquents now who are coming into the system—and we are asking them this whole series of questions about their family situation, their school situation, their friendships, their psychosocial relationships—we are finding that 56 percent of our kids at average age 15 are having sex, and 46 percent are not using any kind of protection.

Senator SPECTER. Judge Sylvester, what are those statistics, again, please?

Judge SYLVESTER. Of the juveniles of our sample population of about 1,681 questionnaires—and, Senator, I thought this was so important that I attached the first data as exhibit B to my report. But it tells us that 56 percent of the juveniles in these 1,681 in the problem severity index study were sexually active, and 46 percent were having sex without birth control. That is for starters.

When I knew that I was coming down here, and I was thinking that, with females, you get them involved in the delinquent system and, of course, you see them on the dependent side, and I worked the dependent side of the court from 1986. So you know what is going on with these kids. But I thought let me see some problem severity indices that were done on kids, women, who have committed a crime serious enough to be in the youth detention center, because that is where we were doing these in March and April.

I have three here. One is a 17-year-old. The problem severity index was done in March 1994. Her charge was aggravated assault. I do not have the details of it, but when we went into her relationships, she did not really communicate very well with her mother. She is in a single-parent home. That is something else that our study has shown, and it does not matter whether they are in rural counties or in Philadelphia County, which is the largest county; the minority of kids are in two-parent homes today.

So she is an example of a child of one family, but she has been having unprotected sex—now, this is a 17-year-old—unprotected sex, and then waiting and worrying about getting her period. Worse is that she said that she has not ever seen a gynecologist or been treated for any STD, yet she disclosed to our interviewer just 1 month ago that she was concerned about having contracted something. For the past 12 months, she has been experiencing pain and discomfort and bumps. She was smart enough to go to a library, here is a bright girl, to see if she could find pictures of what she thought she had.

Now, here is a young lady who is afraid to talk to her mother, is just telling us for the first time. Well, needless to say, we hooked her up with Planned Parenthood. But when you look into her background, you will know why she is not talking to her mother. Her mother's boyfriend was beating her and her mom and her sister up for years before he left. She relates that she feels uncomfortable and awkward about having to suggest condom use. Well, think about that abuse in the family. She just does not know how to handle herself or what to do.

And when I said in my paper that most of these kids do not know that they are not supposed to get pregnant, they really do

not. And a one-time going to someone to be counseled I do not believe is enough when you do not have family.

In the second case, again, this interview was done April 8, 1994, a 16-year-old who is living with her grandmother, not even with her parents. She has been suspended five times, expelled five times from school. She has got a D average. She has not visited a doctor in the last 12 months. She thinks she is 2 months pregnant, and she is planning on raising this child with the help of her grandmother.

Now, she is having sex without taking adequate precautions. If you ask her, can you tell me how someone can avoid getting AIDS, she will answer, just as that other, "You should use condoms or don't have sex." All three girls answered this, yet they got in trouble. And this one is pregnant.

You see these kinds of problems across the board, though. It is not just with pregnancy. It is with the use of violence. It is with truancy. And we believe, as a court, that there is a culture that our kids are living in that says it is OK to have sex, it is OK to get pregnant, it is OK to use violence, it is OK to sell drugs, it is OK not to go to school.

And we have got to develop something in the community that is going to counter that culture if we cannot rely on the parents because the parents are not there. Sometimes a parent is there, but they are so stressed out with other problems that they just do not even have the time to devote to a child who really needs to have time spent, to have the ability to discuss with these kids. But we are seeing that these kids come into our system without any set of values.

So we believe that part of the response to this problem has got to be setting up a mentoring type program. Now, we have done it, we believe successfully, in a number of areas with school-based probation, with Drexel students tutoring our probation kids. Sun Oil funded that.

We have a summer camp with Sun Oil and community involvement, but it is not like the camp where you take the kids out in the woods. I mean these kids are taken to the Hershey Hotel and they go to ball games, and they are taken to the theater. But for 2 weeks they are treated like people who are important. Our probation officers are there, Sun Oil Co., people are there, to just be there for these kids.

We started a truancy project with the school district. I do not mean this in a derogatory sense, but it was just so revolutionary because schools always send their kids at age 15, 16, and 17 to the court. They are not going to school, and the parents are saying they are incorrigible. "Put the kids away. They are just absolutely truant." Well, we said, you know, by that time, these kids have already formed their values. They are not going to school because they did not start when they were 15 years old. We believe that they start very, very young.

So we convinced a previous administration to start a project with us. But, unfortunately, everybody retired in that, so we had to start again. And Dr. Lee is here with us today. He went over to city council and somebody that you know, Senator, Councilwoman Specter, was very much interested in this program because she felt it

had merit. And with that little spark, we were able to put together a truancy project.

Now I am talking about first, second, and third graders. I am talking about kids who are sitting home, and we have the charts for 2 years. I will just tell you about Antonio, 1 of 16 kids in the project.

He is a second grader. He does not know he is supposed to be in school. For 2 years, Antonio was sitting home. In first grade, he missed 39 percent of his school days. In this year, 1993–94, he was absent 52 percent of the time.

When we got involved, and this is what I want to talk to you about. We got involved in a program that involved mentoring, in a program that involved truancy intervention, and in a program that involved our probation officers and social workers. And all of them together descended on these families.

In Antonio's case, Antonio would become a tyrant with his mother when she picked him up after school. I mean he would scream and kick and yell, "I don't want to go to school." The mother does not have any parenting skills, so she lets him sit home. We get in there, get her into some courses on parent effectiveness training. We just tell her, "Why don't you just take a cookie and a little jar of juice when you meet Antonio, and you will see his disposition will change." Well, she starts with that. Antonio is fine after school; he does not go into these rages.

They have been working with Antonio from April to June of this year and he has been absent 2.9 percent; 2.9 percent down from 50 percent. It is just incredible. But the problem is not Antonio. The problem is with the parent who does not understand how to treat these kids, how to reward them. So you do this kind of thing with a mentor, and we think that we are going to be successful.

We followed up on Antonio. We found out Antonio is going to school, but we got this message back: The school threw the mother off the premises. What happened here? Antonio is going to school but the mother cannot go on the school premises? Well, Antonio went home to his mother and said, "Mommy, somebody hit me." Well, mother went to school with him the next day and said, "Antonio, show me who hit you." She grabbed the little boy, held the little boy up, and said, "Antonio, hit him."

But do you see? Antonio now thinks violence is the way to settle problems because he is going to learn that at home. When we asked the mother why she did it, what do you think she said to us? "It's because my mother showed me. My mother taught me to do the same thing." Somebody has got to get in there to say to families, or to kids I should say, "You cannot go this route."

And if you cannot expect it from the family, if you cannot expect it because kids are having kids and they do not really have the ability to bond with little kids over a long period of time, then there is a void in the lives of these children. I can recount stories that would just make your heart ache over what these kids are facing. I really mean it when I say they do not know, because their parents do not know.

Our thought is that we have got to set up a whole set of cultures, of values, to counter what is out there in the street. I need to go back to my PSI for 1 minute; 65 percent of our kids get in trouble

because of other kids, because of their friends. Our thought is that those kids that are the ring leaders today, that are selling drugs, have this negative culture, this bad set of values. We need to set something up in the community real early. And that is the point; early. I am talking kindergarten through sixth grade.

Who are you going to look to do it? Who better than people in the community to act as mentors? Leaders in the community. You would be hooked up early on—not with every kid, because I am not going to sit here and say that we can save every kid. But our idea is to go to the school district, go to the school teachers, and say, "Tell us who the leaders are in the first and second grade." You can tell who is going to be a leader. At that point they are not negative. And let us hook up with a mentor who is really going to be real and interested in these kids.

I just need about 2 seconds to tell you about two things. Mike Gavaghan; he is sitting here. Mike Gavaghan has been involved in baseball for ever and ever and ever. I mean he loves all sports, but he happens to coach baseball. He gets those kids when they are 5 years old, and they start with these kids.

Now, he has borderline kids that he knows are in bad families, or where there are no families, that he saved just because they have put a kid in a discipline, because there is a mentor. Mike is the mentor to these kids. "You know what? You want to play ball? You are going to go to school, you are going to pass this grade, and you are going to conduct yourself in a certain way."

Judge Reynolds, Frank Reynolds, is the supervising judge of our juvenile court. He takes 5 year olds and starts them in a tennis program. Now, what he is really doing is setting up a way of life for these kids. He is the mentor for these kids. I cannot tell you how many kids have gone through his program. He gets them at 5, but what he is doing is saying, "You put your shirt in. You wear that cap straight. You go to school. You will pass. You will play tennis." And then, after he is through forming them, he goes on to the next gentleman. And they are doing this with inner-city kids who are coming from tough circumstances and they are winning scholarships.

PREPARED STATEMENT

They are the best examples of the mentoring program. I was trying to give you this school program that I think is just dynamite. But again, the key is getting in early, involving people who know these families in addition to professionals.

[The statement follows:]

STATEMENT OF ESTHER R. SYLVESTER

In 1991, 59.4 percent of Philadelphia resident births were to women who answered in the negative to the question on the birth certificate "Is mother married to father?" This was the highest percentage since Philadelphia statistics have been available. (See chart prepared by the Philadelphia Department of Public Health for its Vital Statistics Report for 1991 attached as Exhibit A.) There were 29,067 live births in 1991 to Philadelphia women. 17.6 percent or 5,085 births were to women under 20 years of age. The problem is as real for Philadelphia as it is across the nation. I know that this committee has documented the problem. It is the solution to the problem that is not so easy to come by.

Philadelphia Family Court has been collaborating with the University of Pennsylvania in the use of a Problem Severity Index (hereafter P.S.I.) questionnaire for

juvenile delinquents. It is designed to assess family and individual needs. Dr. David Metzger, PH.D at University of Pennsylvania has collected data from 1,681 P.S.I. questionnaires representing urban, suburban and rural Pennsylvania counties. (Attached as Exhibit B). The average age of the juvenile represented was 15. The data from the P.S.I. shows that 56 percent of the juveniles are sexually active; and 46 percent are having sex without birth control. As you can see, Pennsylvania's delinquent youth are making their contribution to the pregnancy problem.

As we explored the challenge of meeting the needs of today's youth, we became convinced that our teenagers just don't know that they should not get pregnant. When you learn about their relationships, very often you find that the love of a parent/guardian is lacking. There is little family bonding or school bonding, low self-esteem and high anti-social conduct. Is it any wonder that 64 percent of our juveniles get into trouble because of friends. (P.S.I. Exhibit B). The reality is that these kids do not have a firm set of values to counter the culture that says it is OK to be truant; it is OK to sell drugs; it is OK to use violence; or it is OK to get pregnant as a teenager.

It is our belief that we must enlist successful members of the community "leaders" to support the ability of the school and family by providing nurturance, guidance and the leadership needed for successful growth. We must identify "Achievers" at an early age, 6 through 12 grades. We would rely on the school district to select children who are motivated, show academic potential and respond well to support and authority figures. Our proposed program is called Leaders Educating Achievers in Developmental Diversity (hereafter LEADD). Few, if any, programs have been undertaken using the concept of Leaders developing leadership qualities in a population of our age group kindergarten through sixth grades.

LEADD is designed to identify and teach young achievers a moral/ethical and values approach consistent with "ideal" standards; that is, integrity, courage, justice, and sacrifice for a common goal.

Acting as mentor/role model, the trained leader will begin a period of orientation with the Achiever. The union will be defined and honed into an honest, helpful, trusting, and reciprocal relationship that is geared to enhancing the leadership qualities of the achiever.

The Leaders will begin to focus on the characteristics of success/leadership, (characteristics he/she themselves possess). Leaders will be trained to clarify the elements of success, e.g., "courage" and "justice" will be identified and applied to everyday situations.

The human reasons behind these values will be expounded. However, the stress will be on conduct, not theory, and the Leaders will present values in a nurturing, informal manner.

Leaders will focus on improving these positive developmental skills known to be characteristics of Effective Leaders:

(1) *Positive self-image.*—Feel comfortable with your image of yourself in everyday roles including: physical, sexual, academic, and social.

Projected outcome.—Achievers with greater self-image are better able to withstand negative influences in the environment.

(2) *Competency.*—Having an image of yourself as someone who can deal effectively with normal encounters in the environment.

Projected outcome.—Leaders will increase self-enhancing thoughts; decrease self-defeating thoughts.

(3) *Achievement.*—The need to experience success in one's endeavors; develop coping skills viewing failure as a model for survival and success.

Projected outcome.—Increased coping skills; appropriate competitive attitude.

(4) *Communication skills.*—Strong ability to relate to peers.

Projected outcome.—Reduced interpersonal anxiety; increased verbal performance.

(5) *Develop cooperation skills.*—Learning how to express and share one's ideas with others in order to solve problems.

Projected outcome.—Achievers will be more adept at resolving conflict and solving social problems.

(6) *Physical training.*—Sound of body; sound of mind. Develop regular physical maintenance skills.

Projected outcome.—Increased positive self-image.

(7) *Positive relationships with parents and authority figures.*—Ability to understand and successfully relate to parents and other authority figures.

Projected outcome.—Increased social adequacy; decreased social fear.

(8) *Forethought.*—Ability to delay gratification; to think rather than to react in emergency situations; planning for future goals.

Projected outcome.—Increased strength to defer own power for the common goal.

(9) *Role taking skills.*—The ability to interpret other people's intentions/feelings.

Projected outcome.—Increased awareness of social standards and goals. Increased conceptualization on how to impact on peers.

(10) *Assertiveness.*—Ability to recognize options in interpersonal relationships.

Projected outcome.—Increase appropriate assertive response. Gain greater self-discipline and personal competency.

(11) *Scholastic endeavor.*—Ability to recognize the awards and merits of an education and to strive to develop these skills to their fullest potential.

Projected outcome.—Establish values, skills, and capability for positioning oneself to make positive changes in the community.

It is our hope that the Achievers in this mentor program will grow up with an alternate set of values that will counter the negative, delinquent behaviors that exist in their communities. It is our hope that the Achievers will have developed the ability to make a positive impact on the "64 percent of teenagers who get into trouble because of friends". It is our hope that LEADD will raise the educational and vocational aspirations of our Achievers, who, in turn, will influence the 82 percent of teens who give birth at age 15 or younger, who are themselves the daughters of teen mothers. It is our hope that by positive example and persuasive discussion achievers will offer another set of values to the children of teenage parents who seem doomed to repeat the problem.

On behalf of Family Court of Philadelphia, I wish to thank the members of this subcommittee for the opportunity of addressing you on one of our country's most serious problem's—teen pregnancy.

EXHIBIT A--PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH VITAL STATISTICS FOR 1991

CHART C. PERCENT OF RESIDENT LIVE BIRTHS WITH LOW BIRTH WEIGHT, LATE OR NO PRENATAL CARE OR TO UNMARRIED MOTHERS ALL RACES--PHILADELPHIA: 1970-1991

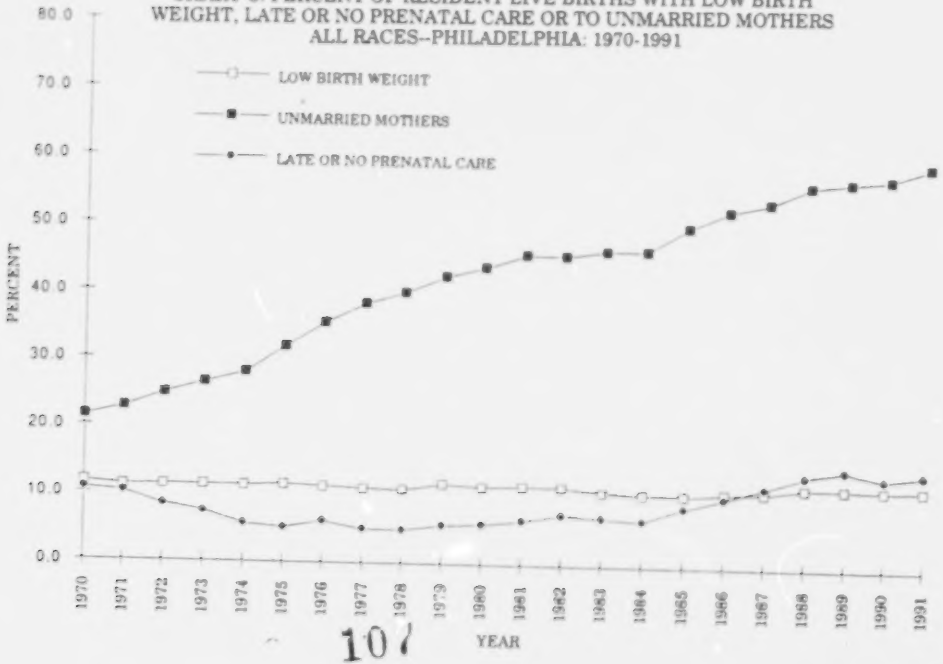

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EXHIBIT B--DATA ANALYSIS PROBLEM SEVERITY INDEX

DAVID S. METZGER, PH.D., UNIVERSITY OF PENNSYLVANIA CENTER FOR STUDIES ADDICTION

OBJECTIVES OF THE PSI

ASSIST IN PROBLEM IDENTIFICATION; ASSIST IN REFERRAL PROCESS; AND CREATE AN INFORMATION SYSTEM/DATA BASE--REPORTS AND ANALYSES

DEMOGRAPHIC CHARACTERISTICS OF 1678 CASES

Age (average =15)	
<12	10%
13-14	26%
15-18	64%
Gender	
Male	81%
Female	19%
Race	
Caucasion	67%
African American	14%
Hispanic	17%
Other	3%

GEOGRAPHIC DISTRIBUTION OF 1678 CASES

URBAN (N=586)	35%
-Philadelphia	
SUBURBAN (N=686)	41%
-Westmoreland	
-Lehigh	
-Lancaster	
RURAL (N=406)	24%
-Schuylkill	
-Bradford	
-Clarion	

GENERAL INFORMATION : LIVING ARRANGEMENTS (N=1681)

Mother Only (N=839)	50%
Father Only (N=153)	9%
Both Parents (N=522)	31%
Other Arrangements (N=167)	10%

LEGAL SECTION : SELECTED QUESTIONS

	N	%	Total
Convicted of Summary Offense	379	36.4	677
Adjudicated Delinquent	84	8.0	95
Alternative Juvenile Disposition	160	9.5	160
Charged Found Not Guilty	168	6.5	73
Questioned & Not Charged	314	30.0	520

LEGAL SECTION : SELECTED QUESTIONS

First Interview (N=869)	82.6%
Age At First Police Contact:	
<12 (N=242)	25.2%
13-14 (N=350)	36.5%
15-16 (N=366)	38.2%
Weapon Taken Away (N=165)	15.7%
Prior Probation (N=153)	14.6%
Have Legal Problem ? (N=136)	13.1%

FAMILY SECTION : SELECTED QUESTIONS N=1681

	Percent
Dissatisfied With Status Quo	13.0
Lived Away From Parents/Guardians	25.0
Household members:	
deceased (N=405)	24.7
hospitalized (N=548)	33.0
arrested (N=722)	43.8
Ran Away From Home	21.0
Have Family Problems?	17.0

EDUCATION AND WORK : SELECTED QUESTIONS N=1681

	Percent
Sporadic Attendance (Past Month)	23.4
Failed/Repeated Grade	55.7
Currently Failing	43.0
Ever Been Suspended	72.6
Total number of suspensions = 5711	
Plan to Graduate	96.7
Ever Fired	6.4
Average Income Per Week	$36.24
Range $0.00 to $495.00	

MEDICAL SECTION : SELECTED QUESTIONS N=1681

	Percent
Chronic Medical Problems	23
Taking Prescribed Medicine	14
Emergency Room Visit (past year) *(N=578) Total Number of Visits=846*	35
Have Medical Problem ?	6

PSYCHO-SOCIAL SECTION : SELECTED QUESTIONS N=1681

	Percent
Treated Psychiatrist/Psychologist	41
Feelings of Depression	45
Felt Worried, Afraid, Scared	40
Trouble Controlling Anger	40
Thoughts of Hurting Self (N=269)	16
Attempted Suicide (N=106)	6
Gotten into Trouble Because of Friends	65
Have Emotional Problems ?	14

DRUG & ALCOHOL SECTION : SELECTED QUESTIONS N=1681

	Percent
Friends:	
Smoke	77
Drink	62
Use Drugs	32
Regular Tobacco Use	41
Average Age of Onset=12.8	
Used Alcohol	63
Used Marijuana	30
Used Cocaine	4
Told To Stop or Cut Down	16

DRUG & ALCOHOL SECTION : SELECTED QUESTIONS N=1681

	Percent
No Use of Any Substances	38
Mother Has/Had Drug/Alcohol Problem	12
Father Has/Had Drug/Alcohol Problem	29
Have Drug/Alcohol Problem ?	4

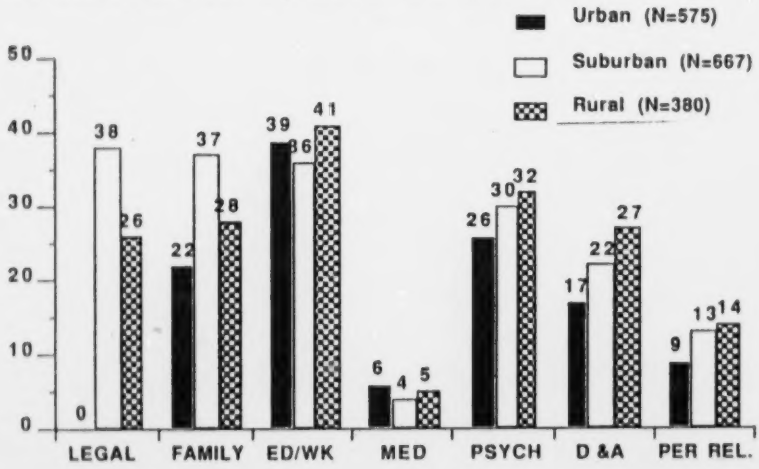
PERSONAL RELATIONSHIPS : SELECTED QUESTIONS N=1681

	Percent
Sexually Active	56
Had Sex Without Birth Control	46
Treated for a STD	4
Physically/Sexually Abused (N=201) *Abuse Not Investigated (N=57)*	13
Have Concerns/Want More Information	5

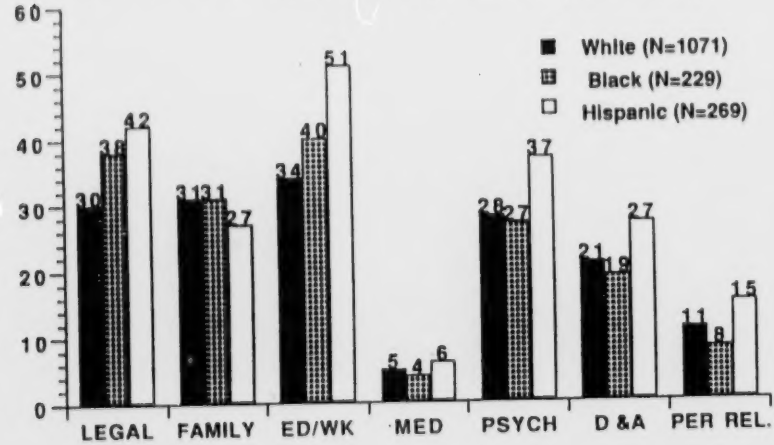
How Do Problem Areas Relate to Each Other?

Family	.53	Psycho-Social
Drug and Alcohol	.52	Personal Relationships
Legal	.34	Education

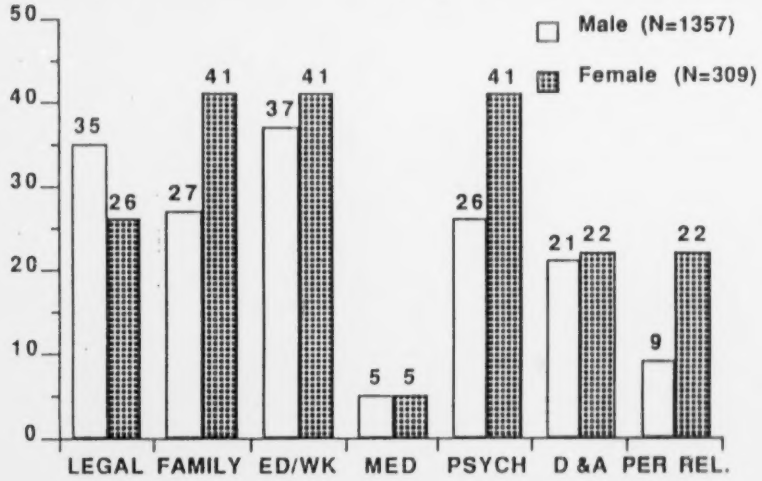
Percent of Cases With Moderate or Urgent Need for Intervention By Location (N=1610)



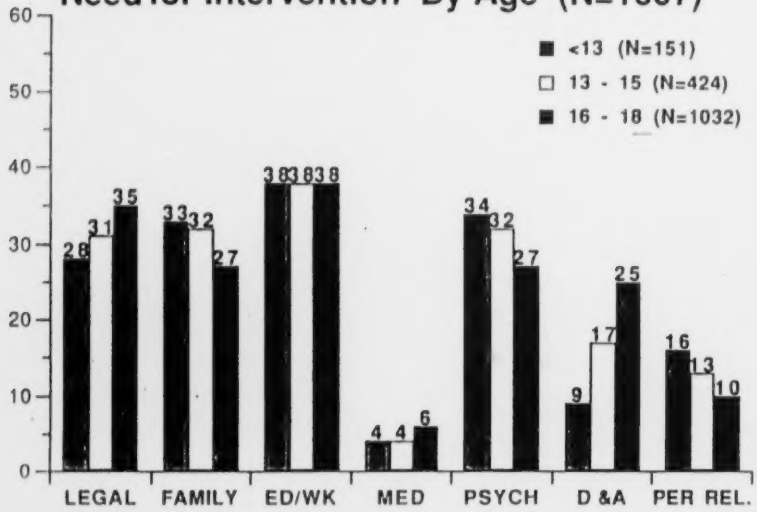
Percent of Cases With Moderate or Urgent Need for Intervention By Race (N=1569)



Percent of Cases With Moderate or Urgent Need for Intervention By Gender (N=1666)



Percent of Cases With Moderate or Urgent Need for Intervention By Age (N=1607)



CONCLUSION

(1) PSI DATABASE ASSEMBLED TO FOCUS ON PROBLEM RECOGNITION.

(2) ASIDE FROM LEGAL PROBLEMS, PO'S RATE FEMALES AS HAVING MORE URGENT NEED FOR INTERVENTION THAN MALES.

(3) HISPANIC ADOLESCENTS ARE RATED AS HAVING GREATEST NEED FOR INTERVENTION (IN ALL AREAS EXCEPT FAMILY).

(4) RURAL COUNTIES PROVIDE HIGHER RATINGS OF NEED FOR INTERVENTION.

EXHIBIT C.--LEADD, Leaders Educating Achievers in Development Diversity

A FAMILY COURT INITIATED COMMUNITY VOLUNTEER LEADERSHIP PROGRAM

FAMILY COURT OF PHILADELPHIA

LEADD

LEAAD is a unique program designed for underprivileged, above-average children who could become successful leaders but for their environment.

It sets into motion a framework for matching an adult "leader" to an underprivileged "Achiever". This pair functions as a "Team". The "Team's" ultimate goal is to have the Achiever become the Leader.

Honorable Esther R. Sylvester, administrative judge of family court.

Honorable Abram Frank Reynolds, supervising judge.

Rae Wardino, manager, dependent court operations.

The final test of a leader
is that he leaves behind him
(in other men), the
conviction and the will
to carry on.

Walter Lippmann

NEEDS ASSESSMENT

In 1962, the Constitutional decision to remove prayer from public schools created a costly void in our American School System. Value laden types of instruction were

de-emphasized; schools feared they would be accused of imposing religious beliefs.

Schools stuck to academics; parents, churches, and the community were left to do moral instruction. However, church attendance was dropping off and what little instruction the children received was narrowly defined within the context of the various religions.

At the same time, the traditional family was, itself, in transition and television was largely influencing our beliefs. For many children, there seemed to be no universal values. Perspectives were developed to compensate for this discontinuity.

The Values, Prosocial, Developmental and Cognitive-Decision Theorists' approaches to Moral/Citizenship Education were considered to have the most significant impact on the field.

The position most widely accepted in the schools was that of the values theorists, particularly one subsumed under it: values clarification. While "values education" may be seen as a broad area, the key feature of their belief was the centrality of values in human action and personality; and the individuals can become conscious of their values and can consciously direct their actions consistent with those values; i.e., to use those values as a guide.

Values clarification, while explicit about encouraging people to consider the personal and social consequences of their choices, affirmed the importance of individual growth, but not at the expense of those around one.

It was a non-sectarian, non-religious approach, but

critics claimed it promoted the worst form of moral relativism, so it is no longer widely used.

Schools began developing programs distinguishing between private morality (religion) and public morality which promoted universal values such as integrity, honesty, and fair play, respect for the rights of others, responsible citizenship, respect of law, and human worth and dignity. These core values, like it or not, are necessary for the survival of man as a social being.

Today, there is a swell of support for the schools to pay even more attention to students' moral development. However, there is also a growing concern from educators and parents alike that schools cannot be "the be all and end all" solution to this problem.

More and more, our elected officials are seeking community resources to assist in dealing with school problems. There is no denial that part of this request stems from the lack of adequate resources in urban schools (economics); however, there is a growing awareness that the community can be used to enrich children's lives and learning experiences.

Philadelphia is rich in programs for children. Big Brother/Big Sisters is probably the best known organization, fostering an adult/child relationship which exposes the child to new interests, activities, and life alternatives. The Police Athletic League provides a mentor/role model program, tutoring and career counselling; giving kids a chance to make better choices in their lives. The Boy Scouts and Girl Scouts, Little League, Church and Civic Associations are other resources which offer children a variety of developmentally enriching programs to this population.

Review of these educational and community programs reveals a variety of approaches attempting to bestow societal values while promoting individual choice. However, while these programs many times accomplish their goals, they do not go far enough.

Desperately needed today is an education program designed to go further; that is, to glean from schools youths who possess the qualities needed to become leaders both now and in the future. To expose them to adult mentors, who through their choices and achievements, have gained success and recognition as productive members of the community.

Sad are those children who have real potential for leadership, who possess a good sense of self and, who, because of insufficient appropriate recognizable leaders within the community, lose whatever chances they have to develop the skills needed to assume a leadership role in society.

Sadder yet, many "would-be" successful leaders wind up "leading" themselves and their peer groups (gangs), down the path of delinquency and immorality.

Too often, children in depressed areas connote success with drug dealers, pimps, and the criminal element of our society to which they are more often exposed. Hence, they emulate those individuals who have the "appearance" of success.

TARGET POPULATION

This proposal follows the premise that an Achiever's development from successful childhood to successful maturity results from his ability to develop the skills needed to succeed in school, achieving full recognition and status within a peer group; and the attainment of a healthy respect for acceptable societal standards.

There is growing concern in the business community today to what is viewed as the systematic distraction of our youthful population. The temptation of drugs is ever present. The disintegration of the nuclear family has drained further support. The term "Latch Key" has been coined to describe an entire class of children without adequate parental supervision.

The trend today is towards community initiatives. Our program allows successful members of the community, "Leaders", to support the ability of the school and family by providing the nurturance, guidance, and leadership figure needed for successful growth.

("Family" as referred to herein, will be comprised of household members in which the juvenile resides. Family members may include both parents; however, one or both of them should be actively employed. In the absence of parents, it may also consist of a grandparent(s) or legal guardian.)

Target audience should be motivated, show academic potential, and respond well to support and authority figures.

Referrals will be made through the School District of Philadelphia. (See Identification and Referral of Students for Program Participation.)

IDENTIFICATION AND REFERRAL OF STUDENTS FOR PROGRAM PARTICIPATION

Description of initial population - A multi-cultural group of 50 to 100 male/female students, grades K-6, ages approximately 6 to 12 years, from different areas of the city.

Determination of Students - Approximately 10 schools within culturally and economically depressed areas. Referrals should

go through School Superintendent's Office to the Program Director. Director will select 5 to 10 students per school.

Written documents which need to be created:

1) A letter/documentation "endorsed" by Dr. Lemme to principals of participating schools informing that their students and parents are to be involved in this program.

2) A contact letter to participating schools (or school liaison member), to inform of the purpose of the program, the goals, the individuals spearheading the program, the extent of teacher involvement required, (e.g., student information profile, school performance, behavior), etc., extent of parent/guardian commitment and responsibility.

3) Description of students who would benefit from participation in this organization, (specifics here would assist a referring teacher/school member in the selection process).

4) Additional recommendations.

INFORMATION NECESSARY FOR STUDENT REFERRAL

Updated rollsheet and Parent Location Card has most of this information

STUDENT'S NAME D.O.B.

PUPIL ID#

PARENT/GUARDIAN'S FULL NAME

ADDRESS/APARTMENT/ZIP CODE

EMERGENCY CONTACT PERSON (relationship to child, if any)

SIBLINGS?
AGES?

WITH WHOM IS CHILD CURRENTLY LIVING? WHO IS THE HEAD OF THIS HOUSEHOLD? IS THIS PERSON CURRENTLY EMPLOYED? WORK LOCATION AND PHONE NUMBER.

SCHOOL ATTENDANCE FIGURES, CURRENT, AND PREVIOUS YEAR.

SPECIAL SERVICES BEING RECEIVED, (counselling, Spec. Ed. placement, Chapter 1, etc.)

BRIEF COMMENTS BY PERSON PLACING REFERRAL ON ANY ASPECTS LISTED WHICH YOU DEEM MOST APPROPRIATE TO CHILD'S SPECIFIC SITUATION. YOU ARE NOT LIMITED TO THE ASPECTS LISTED BELOW:

BEST COPY AVAILABLE

1) Academic potential vs. academic performance (above average intelligence)

2) Level of motivation--effective strategies, if any

3) Interaction with others--strengths/weaknesses

4) Response to support/encouragement

5) Student effort vs. potential

6) Response to authority figures

7) Self-control vs. impulsive behavior(s)

8) subject(s)/activities child enjoys or excels in

BRIEF ASSESSMENT

Relationship with Parents	+	or	-
Relationship with Peers	+	or	-

(Self Confidence)

Self-Esteem	+	or	-
Scholastic Endeavor	+	or	-
Communication Skills	+	or	-
Role-Taking Skills	+	or	-
Physical Conditioning	+	or	-
Leadership Skills	+	or	-

(Forethought)

Lack of Impulsivity	+	or	-

PROGRAM GUIDELINES

LEADD, is designed to identify and teach young achievers a moral/ethical and values approach consistent with "ideal" standards; that is, integrity, courage, justice, and sacrifice for a common goal. Further, to define and enhance those personality traits congruent with sound leadership.

Applicants should fall within accepted criteria, (see attached).

Leaders will meet with achievers on an informal basis, but no less than eight hours weekly. Acting as mentor/role model, the trained Leader will begin a period of orientation with the achiever. The union will be defined and honed into an honest, helpful, trusting, and reciprocal relationship.

The Leaders will begin to focus on the characteristics of success/leadership, (characteristics he/she themselves possess). Leaders will be trained to clarify the elements of success, e.g., "courage" and "justice" will be identified and applied to everyday situations.

The human reasons behind these values will be expounded. However, the stress will be on conduct, not theory, and the Leaders will present values in a nurturing, informal manner.

Leaders will report bi-monthly to the Program Director, unless an "emergency" arises. "Emergency" is defined broadly and can range from appropriate response to the death of an achiever's family member to failure of the Leader and achiever to "bond". In this instance, the Program Director will meet with one or both members of the Team for remedial services.

Leaders will focus on improving these positive developmental skills known to be characteristics of Effective Leaders:

1) Positive Self-Image - Feel comfortable with your image of yourself in everyday roles including: physical, sexual, academic, and social.

Projected Outcome - Achievers with greater self-image are better able to withstand negative influences in the environment.

2) **Competency** - Having an image of yourself as someone who can deal effectively with normal encounters in the environment.

Projected Outcome - Leaders will increase self-enhancing thoughts; decrease self-defeating thoughts.

3) **Achievement** - The need to experience success in one's endeavors; develop coping skills viewing failure as a model for survival and success.

Projected Outcome - Increased coping skills; appropriate competitive attitude.

4) **Communication Skills** - Strong ability to relate to peers.

Projected Outcome - Reduced interpersonal anxiety; increased verbal performance.

5) **Develop Cooperation Skills** - Learning how to express and share one's ideas with others in order to solve problems.

Projected Outcome - Achievers will be more adept at resolving conflict and solving social problems.

6) **Physical Training** - Sound of body; sound of mind. Develop regular physical maintenance skills.

Projected Outcome - Increased positive self-image.

7) **Positive Relationships with Parents and Authority Figures** - Ability to understand and successfully relate to parents and other authority figures.

Projected Outcome - Increased social adequacy; decreased social fear.

8) **Forethought** - Ability to delay gratification; to think rather than to react in emergency situations; planning for future goals.

Projected Outcome - Increased strength to defer own power for the common goal.

9) **Role Taking Skills** - The ability to interpret other people's intentions/feelings.

Projected Outcome - Increased awareness of social standards and goals. Increased conceptualization on how to impact on peers.

10) **Assertiveness** - Ability to recognize options in interpersonal relationships.

Projected Outcome - Increase appropriate assertive response. Gain greater self-discipline and personal competency.

11) **Scholastic Endeavor** - Ability to recognize the awards and merits of an education and to strive to develop these skills to their fullest potential.

Projected Outcome - Establish values, skill, and capability for positioning oneself to make positive changes in the community.

APPLICATIONS

Few, if any, programs have been undertaken using the concept of Leaders developing leadership skills in a population of our age group, (K through 6th grades).

As we are apparently breaking new ground, applications will remain fluid and will initially be much a matter of weighing measures of success.

With their help, Leaders will influence children in a process of self-directed learning, using community resources, and the network which will comprise the "Leader Assembly".

Leaders will actively involve their Achievers in planning and carrying out their self-development projects. The learning experiences of the Achievers will be organized around real-life situations; the result of which will be improvement in the accomplishment of real-life tasks.

Classroom experience will blend with the real world and the Achievers will learn initiative and self-discipline and to evaluate their performances.

The Leaders will motivate the Achievers and empower them to outperform themselves, to learn innovation, and to deal with uncertainties.

Leaders will not only focus on the Achiever's development, but on preparing them to focus on developing their peer group.

Leaders will assist the Achiever in establishing the special dimensions needed for leadership excellence.

Leaders will develop the interpersonal communication skills and responsiveness of the Achiever.

Leaders will motivate Achievers to achieve their fullest potential; to embrace creativity; and to enhance the quality of their life through their own power and self-satisfaction.

The Team will develop an environment of trust, commitment, and integrity inherent in the ideals of American Leadership.

Progress will be monitored through regular meetings between the Leader and the Achiever. This can take place in a formal (work), or informal (home), setting and by the Program Director through interview and assessment.

The Leaders will be provided with a Leaders' Network Directory. This directory will list the names of present

Leaders and the available resources and incentives they can provide.

When available, printed matter on leadership development will be provided to the appropriate team member, as will information regarding the ongoing project.

TRAINING SESSIONS FOR LEADERS

Leaders will be interviewed by the Program Director. Once accepted, they will attend an eight-week series relating how to identify, nourish, and magnify the essential elements of leadership. Presentations will be given by experts in their field. In some cases, the Program Director will present the session:

Sessions will include:

A) "The First Phase" - Objectives include orienting the Leader to the program and to their responsibilities within the program.

B) "Identifying Factors" - Objectives include increasing Leader awareness of the traits needed for effective leadership.

C) "The Team" - Objectives include a working framework for the one-on-one relationship between Leader and Achiever. Leaders will learn methods of earning the Achiever's trust and enhancing the effectiveness of the Team.

D) "Motivation" - The goal of this session is to make clear the role of the Leader in inspiring and motivating the Achiever to reach unrealized, unrecognized, and unchallenged potential.

E) "Values" - Objectives include defining and understanding a value system consistent with the American way

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of life. Also, how the Leader can teach the Achiever to have a positive impact on his peers by being willing to share his power and information.

F) "Choice" - Objectives include a study in Achievers' options. Leaders will learn how to support Achievers' searches and challenges for better/different ways of doing things; and how to disengage from destructive peer relationships.

G) "Recognition" - Objectives include sensitizing the Leader in recognizing the Achiever's accomplishments and to celebrate his successes; to affirm, validate, and appreciate the Achiever's successes.

H) "Triage" - The goal is to teach the Leader to identify potentially harmful situations. The Program Director is always involved at this level.

PROGRAM DIRECTOR

Human Relations Specialist (Psychologist/ Social Worker), capable of training Leaders to effect change in the target population. Must be available for ongoing consultation, training, and orientation.

The Program Director will assure compliance with the programs, goals, and objectives.

ADMINISTRATIVE ASSISTANT

The Administrative Assistant will provide assistance in the areas of fundraising, recruiting, administration, and public relations and will maintain a networking service system for Leaders.

LEADER

A recognized role model within the community. By this it is meant that the Leader has shown a willingness to help others; gets along with colleagues; demonstrates a good example to others; exhibits a positive view towards youth.

PROJECT ASSESSMENT PLAN

As this program is unique, there is presently no known measure suitable to our needs; therefore, Ruth W. Mayden, M.S.S., Dean, Graduate School of Social Work and Social Research, Bryn Mawr College, has offered to supervise the creation of an assessment scale to be developed by the Graduate Department of Bryn Mawr College.

The assessment will be set up to allow for early and continued remedial intervention if the program is failing to meet the goals and objectives set for the Achievers.

Anthony L. Rostain, M.D., Medical Director, Philadelphia Child Guidance Center/Children's Hospital of Philadelphia, Consultation Liaison Department and Member of the Philadelphia Advisory Steering Committee for the Child and Adolescent Service System Program, (CASSP), has offered his services as a consultant so to assure the program's goals and objectives would help the Leaders maximize the positive leadership qualities in the Achievers.

Senator SPECTER. Thank you very much, Judge Sylvester. Let me yield first to Senator Stevens, who has other commitments.

Senator STEVENS. I do have to leave, as I said. I was interested, but until the very last comment, you had not mentioned drugs or alcohol. Do you have any statistics on the intersection of drugs and alcohol as far as the young women are concerned in terms of the teen pregnancy problem?

Judge SYLVESTER. I know from this study that there is a certain percentage of teens who are involved in drugs and alcohol. It is not as great as the 56 percent. But what I wanted to point out is that, yes; there is; 38 percent had not used any substances.

Senator STEVENS. Have not?

Judge SYLVESTER. Have not; that is right.

Senator STEVENS. So it is 62 percent who have?

Judge SYLVESTER. Do you know what happens, though, Senator? They will not say that they use, but then if you ask them if their friends use, they will say like 77 percent of our friends smoke, 62 percent of our friends drink, 32 percent of our friends use drugs. Well, you know, they are the same friends that are getting these kids in trouble. So you have to start analyzing. Yes; it is a problem. It is a problem with the parents.

Senator STEVENS. Thank you.

Senator SPECTER. Thank you, Ted.

Judge Sylvester, thank you very much for your written statement, the statistical booklet, and your oral testimony. When you recount the problems in the community of Philadelphia—and you did a very good job in articulating them. I certainly recognize them from my days as district attorney and staying in touch with the problems in the community.

And you pose a really gigantic task when you identify so many of the problems with the parents who do not understand the values, as illustrated by the mother who held the young child at school who had hit her son so her son could hit back, under those circumstances. And you talk about the resources of the family court being brought to bear on the problems and about your chief probation officer coming into the field.

But what do we do just in terms of the quantitative number of people whom there are to deal with and the limited resources of the court and the difficulty of organizing enough mentors, community volunteers? Where do we go in order to tackle the kind of massive problem that you face say in the city of Philadelphia?

Judge SYLVESTER. If you look at it globally, I think you kind of just want to like fold up and probably take on the form of a court that is not activist, and you just kind of react to problems. But I do not think that we can do that anymore.

In this truancy project and in a lot of the connections that we have to kids, the fact that the court is there, even in the background, is a psychological motivator, so people do things. So I think it is important for the court to be involved. But, by the same token, we have got to collaborate with other agencies and we have got to look to ways to funding these special programs.

I do not think you have one answer to this problem. I think you have everybody here who is coming and bringing their collective knowledge and who is training young women to effectively say, "No, I don't want to have sex." I mean, that is as important as getting a leader attached to an achiever so that we could end up with a kid who is going to be strong in the community, who is going to influence that 64 percent, but to the good.

So I do not see it as that massive. I think if we sit down, strategize with the schools, hopefully the Federal Government will see that mentor programs are important, do a piece of the funding for that, and let's see where we go. Let's demonstrate what we can do for the kids.

I know this. The studies have shown that kids respond and overcome the odds when they have someone in their lives who cares.

Senator SPECTER. Judge Sylvester, your statistics are interesting in many respects. One perhaps especially significant, when you cite the 1,681 questionnaires, which is a pretty good-sized sample, and you say that 46 percent had sex without birth control. This is in very sharp contrast to a study which was just released yesterday from the Allen Guttmacher Institute with a finding that some 72 to 84 percent of teenagers had contraceptives for the first time that they had sex.

Now, the question which comes to my mind is whether more of the young people being questioned may give an answer which makes them look a little better.

Judge SYLVESTER. I hope you are right, Senator.

Senator SPECTER. The Guttmacher study was encouraging to the extent that it suggests a lot more thoughtfulness and a lot more care among teenagers, and we all hope that is true. But it is quite a disparity on 46 percent had sex without birth control contrasted to 16 to 28 percent, if you invert the 72 to 84 percent who had contraceptives the first time they had sex.

I would be interested in your comment on that.

Judge SYLVESTER. You know, we had to wait until the sample was large enough to do this. It is interesting. I just had a meeting with Professor Metzger this past week, Judge Reynolds and myself and several of our staff. Now I did not have the recent study, but it could be the way that the interviewer is asking the question, is it not clear. So we are going back and we are going to look at this.

I mean, the question on sexually active is just sexually active, and 56 percent answer. Now, that is not all Philadelphia kids. As I indicated, 35 percent of that 1,678 cases were Philadelphia; 41 percent suburban—that is Westmoreland, Lehigh, Lancaster—and 24 percent of those kids came from Schuykill, Bradford, and Clarion. And they are getting these answers across the board. That is what is astounding to us.

Senator SPECTER. Is there any significant difference between the city of Philadelphia and say Bradford County, which is a rural county along the New York border?

Judge SYLVESTER. Maybe not. Maybe they are influenced by New York. But I know that, as we are looking at this data, it is showing us that those kids in the rural area have more needs than our Philadelphia kids.

Senator SPECTER. More what?

Judge SYLVESTER. More needs.

Senator SPECTER. Needs?

Judge SYLVESTER. Just general needs. When we went to Metzger, I said, "You know, that could be a positive." That could mean that Philadelphia is doing more for its kids and the rural county is just doing less, or they wait until the problem is so severe and the kid has no place to go but is just for the first time.

And we do not know the meaning of all of these statistics. Although I did not have a problem with these numbers and did not discuss it with the professor. But I think we have to go back to visit it in view of these new statistics. And we certainly will do that.

Senator SPECTER. Judge Sylvester, I have more questions, but I want to yield to my distinguished colleague, Senator Gorton from Washington, who is here, and I know he has another commitment.

Senator GORTON. I will pass.

Senator SPECTER. OK.

On the issue of teenage pregnancy and prenatal care, Judge Sylvester, there is a very large problem nationally with young women and not-so-young women who give birth to low-birthweight babies, babies which weigh 1 pound, 18 or 20 ounces. I first saw this problem a decade ago in Pittsburgh, which had the highest infant mortality rate among African-American children.

We know from the works of Dr. Koop and others that if they had a series of prenatal visits, four at a minimum, that the low-birthweight babies could be substantially reduced and perhaps eliminated. This is a problem, a human tragedy, where these children carry these scars with them for their lifetime, and it is enormously expensive for the community, in the range of $150,000 a child from the time that they are released from the hospitals, and it is a multibillion dollar expense nationally.

My question to you is: Do you know of any reason why there should not be some basic information given to these young women in schools? There is no question here about telling them about sex or about encouraging sexual activity. They are already pregnant. But is there any reason why, in the school setting, or whatever other way we could reach these young women, that they should not be told about the necessity for prenatal care?

Judge SYLVESTER. I agree with you. When you take a look at the vital statistics report—and as I say, this was for the year 1991—11 percent of 1989 births were in this category. It was from 6.7 percent to white mothers, 6.7 percent to Asian mothers. I mean it is just across the board. And it is ignorance. I think that if a youngster gets in that situation, she is going to have to go to the place that she feels comfortable in, and probably that is going to be a school-based center, perhaps a medical center that is based at the schools.

I know, in Philadelphia, we are planning to have in the community about 10 community-based centers. We are even converting the recreation centers to youth access centers where there are going to be a lot of services to kids. I think it is really important for us to plan to give that information to kids.

Every time I had a pregnant child in dependent court—and as you know, that is not the delinquent side; that is just somebody

who has a problem because there are problems at home—and you ask, "Are you going to a doctor," they just are not, because there is nobody at home to say you have got to go. Because probably it is too difficult. It is financially impossible.

Senator SPECTER. How about someone at school to say, "If you are pregnant, prenatal care is vital," because of reasons one, two, three?

Judge SYLVESTER. That is right. And I think you are going to hear this. I mean, I think you are going to hear this from Philadelphia. I think that there are plans to do this kind of thing, and there is nothing wrong with it. I think that some of the schools have to be—and they are planning this—centers that do more than just teach kids. They are going to have to give out vital information. I think they have some really good teen programs, and I think you are going to hear it.

But there is absolutely nothing wrong with that. There is nothing wrong with our probation officers getting a pregnant female in, as we did in this case, and say, "You're 2 months pregnant? Young lady, you are going to go to Planned Parenthood, and we are going to get you a doctor." And kind of overseeing that.

Senator SPECTER. Judge Sylvester, as you know, there is a lot of discussion nationwide focusing a great deal on Capitol Hill about changing the welfare system, with the question being raised as to whether the welfare system encourages teenage pregnancy. And there are some suggestions that there ought to be no increase in welfare payments for subsequent children who are born to unwed mothers. I would be interested in your thought on that subject.

Judge SYLVESTER. I indicated to you that I was assigned to dependent court, abuse cases, neglect cases. And when you see the harm that is done to these little, innocent children by their parents, you want to cry out. And the reaction is, let's get these children into a safe environment.

It is another kind of abuse. I mean why does that infant child have to suffer for the sins of the parent? See, I think you have to start with—and, again, it is early on—building the self-esteem of the person, building a need to just, "You have to go to school. That is the right thing to do, because then you are going to have a job, because then you will be able to go to college if you can, and then you will be able to have your family." And you have to instill this.

I think people are good, and I think that people will, kids will, understand the message if they get the message. It is as simple as your next witness telling these kids how to say no. They do not know how to. I mean, how does a kid like this 17 year old who has been abused by her mother's boyfriend? She said that she called the police so many times that the police knew her mother by the first name. How does that kid get to say no? I mean she has been abused. Her first sexual encounter was a forced one. I did not tell you that.

Somebody has got to teach these kids to say no. They will respond if we take the time. I do not think we can afford to punish these little infant kids.

Senator SPECTER. Judge Sylvester, when we talk about teenage pregnancy, we frequently put in the term "unwanted" teenage pregnancy in advance to distinguish unwanted teenage pregnancies

from teenage pregnancies which are not unwanted. And the suggestion has been made—and I raise the subject and ask you these questions inquiring, because those of us who are here on the Senate panel are pretty far removed from the issue. And that is why we appreciate you and the other witnesses coming in to tell us your experiences dealing with the problems on a day-in and day-out basis.

But to what extent, in your view, are these teenage pregnancies not unwanted but wanted? Some of the testimony which we have heard, or other information which has been provided to us, suggests that young teenage women want a child to have someone to love; that it is not an unwanted situation but it is a pregnancy which, simply stated, is not unwanted. Is there any basis to that in your experience?

Judge SYLVESTER. I am sure there is. And that one statistic, that 82 percent of the 15 year olds and under who give birth were children of teenage mothers tells you something. But what I think it tells you is they are just seeing——

Senator SPECTER. Eighty-two percent of the teenagers were children of teenage mothers; 82 percent?

Judge SYLVESTER. It is 82. I mean, I did not make up these statistics. I was shocked; 82 percent of teens who give birth at age 15 or under are themselves daughters of teen mothers. What is that saying? And I am sure that teen mother is not capable of bonding with that child. That child grows up with this sense of not having anybody that cares. That is the word, a caring person. Sure, that child they think is the response.

But I have to tell you something, Senator. I was surprised, because I read with interest a survey that Martin Luther King students did. These students designed a questionnaire and sent it out to 9th, 10th, 11th, and 12th graders. Do you know what the answer was to the question, did you want to get pregnant? "It was a mistake." By far, that was the first and prime reason. Yes, sure; there were kids that said that they needed love, but, "It was a mistake."

I get back to knowledge. They do not know. They do not know how to protect themselves, and they need somebody who is going to be there all the time for them, somebody to whom they have bonded.

Senator SPECTER. You say most said that it was a mistake. To what extent, if at all, were the answers given that they became pregnant because they wanted to have a child?

Judge SYLVESTER. Senator, I do have somewhere in these papers the actual questionnaire and the whole design. I thought I had it here. And I can leave it with you.

Senator SPECTER. If you could provide the answer to us later, that would be fine.

Judge SYLVESTER. Yes; if you do not mind. I just cannot put my finger on the survey itself.

[CLERK'S NOTE.—The information referred to is included in Judge Sylvester's prepared testimony.]

Senator SPECTER. Judge Sylvester, the related question is: To what extent, if at all, does the welfare system encourage teenage pregnancies? When Dr. Elders was in, we had a discussion on the question as to whether there was any significant impact on the

availability of welfare providing an incentive for teenage pregnancy, so that if you cut off welfare or limit welfare, you will cut down on the pregnancies. And again I say, I am not judgmental. I am asking the question. What insights do you have from your experience on that issue?

Judge SYLVESTER. I do not believe that the kids are thinking about the responsibility that a child brings. I mean I do not think they are thinking about financing the needs of the children when they get pregnant. And I think, once they have the children, they realize that they have got this gift now who is supposed to require all of a mom's time. And when you get a teenager who is the mom, she is not capable of doing that. And then the child is handed over to someone else in the family, hopefully, and then sometimes the child ends up——

I guess I am talking around this. I am not sure that kids are thinking, "I am going to get pregnant because somebody is going to provide support." I think it is like this young lady. "My grandmother will help me raise it; my family will," even though that grandmother may have five other kids. They are not thinking about that. I am not sure that is what is motivating these kids.

Senator SPECTER. You have no judgment on whether they are motivated by the possibility of a welfare check?

Judge SYLVESTER. I do not.

Senator SPECTER. OK. Well, thank you very much, Judge Sylvester. You have given us a lot of food for thought and a lot of statistics and reports for reading, so we have some homework.

Judge SYLVESTER. Thank you.

Senator SPECTER. We very much appreciate your coming down.

STATEMENT OF COLEEN KELLY MAST, SEX RESPECT, INC.

Senator SPECTER. We will now turn to panel II: Coleen Kelly Mast from Sex Respect, Inc., Bradley, IL; the Hon. Rotan Lee, president of the Philadelphia Board of Education; and Dr. Rosetta Stith, director of the Paquin School. We welcome you here and express our appreciation for coming.

Ms. Mast has been involved in family life education since 1975 as a lecturer and author. She holds a master's degree in health education from Western Illinois University and a bachelor of science from Quincy College. She is the author of two curricula, "Sex Respect: The Option of True Sexual Freedom," and "Love of Life: A Christian Sexual Morality Guide." Ms. Mast, we look forward to your testimony.

Ms. MAST. Thank you, Senator. It is a pleasure to be here, and I am happy to relay to you some very successful results of a phenomenal program that is changing the lives of a lot of kids throughout this country so they do not get to the point where they have to go to the judge and try to repair a torn-up life.

What I see today is teens are crying out for help, and what we have to decide is how do we respond. Their cries are:

I was hungry for love, so you formed a committee to discuss my situation. I was thirsty for directions so you told me to figure out my own values. I was one-half naked when I arrived at school, so you changed the dress code so I would think I was OK. I was illiterate, I could not read, I was not doing well at school, so you gave me Norplant or Depro-prevera, and I could not even read the side effects. And I was lonely, so you gave me a condom.

What I have seen in today's young people throughout the country—and I do numerous youth rallies, talk to thousands and thousands of teens besides those I have worked with throughout the 10 years in my classroom—is, compared to 25 years ago, we have less teens but more teenage pregnancy; we have less births but more illegitimate births; we have more medicines but more diseases we cannot cure; and, very sadly to say, we now have more sex and less love.

I think that is the crux of our big problem. What if we tell teens that sex expresses love and they do not know what love is? How do they know when to have sex? And the program that I developed called "Sex Respect" teaches kids the difference between sex and love, how and when sex expresses love, and when it is really just using another person. This program did not come out of the air or academics. It came from 10 years of experience working with teens.

When I was first teaching in a school situation, I was tutoring young girls who were pregnant and during a certain time of their pregnancy were unable to attend school daily. It was too many hours, too uncomfortable for them. And I worked with them each day. I counseled also a lot of girls who already had been on birth control, were taking that. And what I found was a lot of unhappiness, a lot of emotional problems, a lot of things that birth control was not helping, and that even the counseling and tutoring was not helping.

So when I would go back in the classroom, Senator, the next hour I would think:

What can I do for this group of kids, this next class that I am going to teach, that will help prevent some of the emotional and psychological trauma that was going on with the young people that I was working with individually?

I saw that birth control was not going to help some of that trauma. Maybe a few pregnancies, a small percentage of them. But what was really going on was, as a culture, we tell them that sex is OK as long as we do not see some physical results of it. And I saw it perpetuating a lot of unhappy kids.

I do not want to continue ignoring the emotional/ psychological/ social consequences of sex outside of marriage. And when I began to write the curriculum "Sex Respect" for our graduate school program curriculum guide, I saw a tremendous response from other health teachers that I was working with. Many teachers who teach in the classrooms in health education are unhappy that they have to teach sex education in the first place. They are a coach who just wants to keep tenure that has to teach health education or sex education.

So I developed a program that is very easy to teach. It is in a workbook form for the students. It has a simple teacher's guide with measurable objectives for the teachers. And also, very importantly, which makes this unique, is a parental component. We have a parents' guide, a parents' program, a parents' meeting that goes along with the "Sex Respect" program.

What we do, instead of the school taking over for the parent, we teach the parent how to communicate with that child on these specific issues that we are learning in school, so we have the peer pressure taken care of in class. Everybody in the classroom has heard why and how to save sex for marriage from a public health

perspective, why using people for your selfish reasons is not good, why this program can help you appreciate your marital sex life later on, why sex is something good and not dirty, and how saving sex for marriage can be positive in terms of their understanding the purpose of dating, how to learn about life, how to learn about love.

When I was working on my master's in health education, I could see that every other area of health education was focused in a direction toward health or wellness, whether it is stress management, say no to drugs, alcohol use. And we always had a focus. So I began to look at sex education. I thought, "Well, why aren't we giving a specific focus?" And I began to examine and research what is most healthy, what is the healthiest choice, where do kids loose their freedom and, of course, what are the results.

And it need be said that the teenage pregnancy rate and sexually transmitted disease rate among virgins is nearly zero percent.

And then the psychological/emotional effects are paramount, even of teens who do not get pregnant. Very interestingly, when we are talking about family, the November 1991 "Journal of Marriage and the Family" reports a national study that nonvirgins have a divorce rate that is 53 percent to 71 percent higher than virgins. And this study affirms that saving sex for marriage is a significant variable in improving American family life and reducing stress in both adults and children.

So, in the "Sex Respect" curriculum we present information to both parents and teens and to teachers in their training seminars that most other sex education courses ignore. It is given to the kids who are confused and misled. And it has proven—and I have the proof, the statistics, here and you have more of them with you there in the rest of the report—to reduce the teenage sexual activity rate, not just the teenage pregnancy rate, in those teens who take the course.

The overwhelming response of teens who do take the course is extremely positive. They find it interesting, positive, fun, and informative. Many kids who have been sexually active before they come to the course are pleased to know they can say no. They learn skills how to say no, and their decision to wait then is affirmed.

Just for example, a young girl named Amy who wanted to come with me today. She came to me when she was 19 years old and wished she had met me when she was 15 or 16. She had already, by the time I met her, had numerous years of sexual activity, been raped, had an abortion, was completely confused, barely raised herself or by alcoholic parents, and had no focus or direction in her life.

And that girl merely needed some encouragement, some support, some information to turn her life around, and she has. She is married now, has two children, and is still working at overcoming and healing what happened to her in the process before she was told what is the truth about sex and love. So kids are relieved and happy to know it is OK to save sex for marriage.

Another girl in California, her name was Susan, was taking the "Sex Respect" course in her school as a sophomore. Her mother slept with—you know, had men spend the night, slept with anybody that she went out with. Nobody had ever told her she could

say no. She even said to her teacher, "Boy, I didn't even like doing it anyway. I'm so glad I can say no." And no one had ever given her an intelligent reason, told her why this was better for her health. We are amazed at the number of kids that respond so positively.

Some criticism comes from maybe 40 or 50 year olds who read the course themselves. It imposing guilt on them. They have not reconciled with their own sexual past. Rather than just looking at how this is reaching young teens, later teens, those who have not yet seared their conscience are very, very responsive to this.

The values taught in the "Sex Respect" are those which made our country strong. They are simply self-control, other centered love, maturity, the dignity of human persons, respect for male and female, mental health, physical health, emotional health, and the health of family and society.

The students, generally in grades 7, 8, 9, or 10, along with their teachers and parents, in over 2,000 school districts who have tried this program learn why and how to save sex for marriage for reasons of personal and public health; the difference between sexual freedom and sexual impulsiveness; the difference between human sexuality and animal instincts. What do you do on a date if you do not have sex? How far do you go before you loose your freedom to make a good decision? And that includes alcohol, too, as you had mentioned earlier.

How to make the most of your dating experience, and what do you do to have fun if you do not drink and have sex. How to counteract negative influences on their sexual decision-making. How and why to stop having sex if you have already done it. The emotional, psychological, and physical consequences of sex outside of marriage, not just the physical. The reality of sexually transmitted disease. How saving sex for marriage can help your marital sex life become more beautiful. The importance of growing up before you become a parent. And how to analyze and think about sexual influences and decisions so you make informed decisions rather than falling into situations.

I think one of my favorite statistics——

Senator SPECTER. Ms. Mast, could you sum up now, please?

Ms. MAST. Sure. One of my favorite statistics of the results are those kids who before the course said—80 percent of them changed their minds saying, "If somebody asked me to have sex, I would probably have just done it and not thought anything about it; I would have done it anyway." And 80 percent less said that after the course.

When students are receiving that clear message, we have seen significant reduction in teenage pregnancy. A team of investigators from the Institute for Research and Evaluation, as well as a study from the Department of Health and Human Services done from 1986 to 1989, showed, of those students taking the "Sex Respect" course, males reported pregnancy rate of their partners were 43 percent less than the control group, 45 percent less pregnancy rate in females 1 year after the course. Even 2 years later, there was a 39 percent less rate in males reporting pregnancy of their partners, and still a 45 percent less pregnancy rate in the females than in those who had not taken the course.

Some people question abstinence education. "Well, the kids are going to do it anyway. What are you going to do for them?" And in answer to this, the statistical results were increasingly significant. The attitude was proven to be a reality of that 80 percent reduction of "probably would not say anything and just let it happen" to students measured in the lowest values group compared to the control group. A study 1 year later reported the largest difference of 40 percent more who remained virgins. So it is interesting to see that even low-to-mid-values teens are extremely responsive to this program.

My job is not to appropriate money, as yours is. I work out there in the trenches with kids every day, and I love teenagers. This program was developed to meet their needs, and there are really no politics involved. So there are five simple challenges that I would like to present to you.

One is to look at those schools that do implement the "Sex Respect" program in its entirety and, for those that commit to do that, to provide some funding for them, because it does include staff training, classroom instruction, and a parental component. So many schools who try to implement parts of the program or do it with funds that are available——

Senator SPECTER. Ms. Mast, could you please sum up?

Ms. MAST. Sure. I am at my conclusion now. I have three or four more sentences.

They try to write their own program and find that it is not as successful.

I also have a concern about those organizations who are politically based that oppose abstinence education because they are in the business of promoting birth control and abortion. We find often a school that has freely chosen to use this in their district is getting harassment with nitpicking legal attacks.

I also would challenge you to look at what is coming across the airwaves. The erotic and self-centered sexual information under the disguise of entertainment is our main kids' sex education, whereas it is really only bringing about the basal instincts of the sexes.

PREPARED STATEMENT

And publicly, finally, through education, keep focused on the preventative health needs of children so we are not spending so much money on the rehabilitation. And the reality of emotional need for true love and commitment must come out through our education. The kids need proper information, motivation to save sex for marriage, without allowing the latest fads of political correctness to confuse us and blind us from the truth about the meaning of sex and love, and we will find generations propagating more fulfillment rather than using people.

[The statement follows:]

STATEMENT OF COLEEN KELLY MAST

TEEN PREGNANCY -- THE ONLY TRUE SOLUTION
is
SEX RESPECT: THE OPTION OF TRUE SEXUAL FREEDOM

Today's teens are crying out for help. How do we respond?

I was hungry for love, so you formed a committee to discuss my situation.

I was thirsty for directions, so you told me to figure out my own values.

I was half naked when I arrived at school, so you changed the dress code so I'd feel like I'm OK.

I was illiterate, so you gave me Norplant and Depro-Provera, and I couldn't even read the side effects.

I WAS LONELY, SO YOU GAVE ME A CONDOM!

Compared to 25 years ago, we now have:
less teens, but more teen pregnancy
less births, more illegitimate births
more medicines, yet more sexual diseases we can't cure
and very sadly, we now have
MORE SEX, AND LESS LOVE.

If we tell teens that sex expresses love and they don't know what love is...how will they know when to have sex?

The SEX RESPECT Program teaches the difference between love and sex, and when and how sex expresses love, and when it is really just using another person.

What good is it to enable teenagers to have uncommitted sex acts without teaching them how to love?

Why do we think it's any better if they do it with birth control?

Why do we continue to ignore the emotional, psychological, marital and social consequences of premarital sex, while focusing on the physical and economic symptoms?

Senators, let us first examine the misplaced focus of the goal of this hearing: that of 'reducing unintended births'.

What if there was a course that delivered those results and much more education in loving and living?

Then take a look at the objectives and effectiveness of the SEX RESPECT Program which educates for healthy human sexuality and substantially reduces the incidence of teen sexual activity, thus reducing the likelihood of all of it's symptoms.

Many teens, especially those who do poorly in school or have troubles at home, actually intend to have a baby in hopes of finding the

love and acceptance they are missing. They intend to give birth, while they still don't understand life, love or parenting. Education in, or funds for birth control or abortion will never solve their problems, but only give an illusion of aid. I suggest focusing on the reduction of teen sexual activity, so they may have a better chance to learn about life and love, and have time to get an education that may help them become more productive citizens.

Unintended births are only a symptom of our cultural misunderstanding of human sexuality. So don't try to put a band-aid on a cancerous mole.

--What we see today is a culture that has more sex and less love.
--What we need is more love, and more of the sex to be more loving.

Thank you for caring enough about teens to hear about the most effective abstinence program available, SEX RESPECT: The Option of True Sexual Freedom which teaches teens that "love, not sex, is the big deal in life".

This presentation prepared for the Senate Appropriations Committee will briefly focus on the two points which support the current success of the SEX RESPECT Program:

1. Why abstinence and why not birth control?

2. Why SEX RESPECT is the most effective program available, proven by studies and results from teens who have taken the course.

SEX RESPECT is a health education curriculum for school and home which focuses on teaching young teenagers how and why to abstain from premarital sex. I developed the SEX RESPECT program over a ten year period of working with thousands of adolescents in the area of sexuality education, culminating in the curriculum guide written as an assignment for a graduate school course in 1983. Because of the demand from other health teachers, I put the program into an easily teachable form which now includes workbooks for the parents, teacher and students, two videos, a staff training seminar and parent meeting information.

A good health education curriculum (whether in drugs, alcohol, nutrition, etc.) is always focused in one direction toward the optimal health of the individual and society. Sexual abstinence is certainly the healthiest choice for teens.

The teenage pregnancy rate and the sexually transmitted disease rate among virgins is approximately 0%.

The psychological and emotional side effects of teen sex are paramount, even in those teens who do not get pregnant.

The November 1991 Journal of Marriage and the Family reports a national study showing that non-virgins have a divorce rate that is 53% to 71% higher than virgins, (during the years 1965-1983). This study affirms that saving sex for marriage is a significant variable in improving American family life and reducing stress on both adults and children.

The SEX RESPECT curriculum is presenting information about human sexuality and love that most other sex education courses ignore. This information given to today's confused and often misled teens has been proven to reduce the sexual activity rate in teens who take the course. Those programs that embrace the "comprehensive" and "contraceptive" approaches have drastically failed to reduce the teen sexual activity rate, and are not really as "comprehensive" in their understanding of the human dimension of sexuality. Often, misguided critics of our program take the course personally as if it was written for them as adults and, if they were victims of the "sexual revolution" they find it convicting. Teenagers do not see it this way at all.

The overwhelming response of teens is that they enjoy taking the SEX RESPECT course, they find it interesting, positive, fun and informative. Many teens who have been sexually active prior to taking the course decided to stop, and many who have waited so far are affirmed. These are truly healthy outcomes for today's young people who are desperate for hope and values. They are actually happy and relieved to know it's OK to remain a virgin or to stop having sex and wait until marriage.

The values presented to public school students taking the SEX RESPECT Course are those which make our country strong. They are, as listed in the parent guidebook on page 13: "self-control, other-centered love, maturity, dignity of human persons, respect for male and female, mental health, physical health, and the health of family and society."

Students in grade 7, 8, 9, or 10, along with their teachers and parents can learn:

-Why and how to save sex for marriage for reasons of personal and public health.
-The difference between sexual freedom and sexual impulsiveness.
-What do you do on a date if you don't have sex?
-How far do you go before you lose your freedom?
-How to make the most of your dating experience.
-How to counteract negative influences on our sexual decision-making.
-How and why to stop having sex if you've already done it.
-Emotional, psychological and physical consequences of sex outside of marriage.
-The reality of sexually transmitted diseases.
-How saving sex for marriage can help your marital sex life become more beautiful.
-The importance of growing up before you become a parent.
-How to analyze and THINK about sexual influences and decisions so you make informed choices rather than "falling into" situations.

. . . All in a light, easy to read and remember format at an eighth grade reading level. The textbook is designed for integration and response. SEX RESPECT is the most effective abstinence education program available to public schools. It is used in over 2000 districts in the United States and has been sold in 23 Foreign countries.

Why does abstinence work and contraception doesn't? Even when teens use contraception and use it as they are taught, they experience a higher failure rate. Therefore, the more teens we have using birth control, the greater the number of teen pregnancies. (see appendix A)

Dr. Jacqueline Kasun, Sociologist and global population expert reports that "states which spend most heavily to promote free contraceptives and abortions have the highest rate of premarital teen pregnancy. The rate of premarital teenage pregnancy is more than twice as high in California as in Idaho or South Dakota; and California spends more than four times as much per capita as the other two states on free birth control. THE NOTION THAT TEENAGERS CAN BE DETERRED FROM BECOMING PREGNANT BY MORE AND EASIER ACCESS TO CONTRACEPTIVES AND ABORTIONS IS LIKE EXPECTING PEOPLE WHO ARE GIVEN FREE GASOLINE TO REDUCE THEIR DRIVING."[1]

For reducing teen births through contraception education, school-based programs are but a bent arrow. However ineffective, bent arrows do offer the illusion of action.

Contraceptives are a poor substitute for the difficult yet loving work of teaching adolescents to be responsible adults who can make moral distinctions. How are adolescents to learn self-control, fidelity, responsibility and courage when so many adults fail to teach and model such qualities themselves?

When students are receiving the clear healthy message of abstinence from their school teachers, parents and community leaders, the peer pressure grows more positive. Because of this, the SEX RESPECT Program gets results in inner cities, small towns, unwed mothers homes and even crisis pregnancy centers.

"Aunt Cherie's Home" in Bakersfield, California is one of many success stories. They have incorporated SEX RESPECT into their program for pregnant Hispanic girls, and have had very few documented repeat pregnancies after teaching the girls why and how to say "NO" to future sexual activity outside of marriage.

A 3-year-study funded by the Department of Health and Human Services Office of Adolescent Pregnancy Programs showed significant attitudinal changes in students after taking the SEX RESPECT course:

Before taking the SEX RESPECT course, 41% of the students thought it was important to save sex for marriage, and after the course, the number rose to 59%.

Before the course, 44% thought that a teen who has had sex outside of marriage would benefit by deciding to stop having sex and wait until marriage. This increased to 63% after taking the course.

Before taking the SEX RESPECT course, 41.5% thought that the sex act was wrong for unmarried teens as long as no pregnancy resulted from it. . . this increased to 61% after the course.

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[1]Kasun, Jacqueline R. "The Economics of Sex Education" A position paper, Department of Economics, Humboldt State University, CA, 1986.

When the students were asked if there are benefits to waiting until marriage for sexual intercourse . . . 35% answered "yes, a lot" . . . before taking the course. After the course a total of 53% said there were a lot of benefits to waiting.

An independent team of investigators from the Institute for Research and Evaluation studied the effectiveness of the top three abstinence programs in the country. On all counts, the SEX RESPECT Program's higher ratings were statistically significant, particularly in these areas:

Pre-post changes on: affirmation of adolescent abstinence, grade 10 rejection of permissiveness, high school affirmation of abstinence, junior high (see appendix B)

Of students who took the SEX RESPECT Course, males reported pregnancy rate of their partners were 43% less than the control group, 45% less pregnancy rate in females one year after the course.

Even two years later there was a 39% less rate in males reported pregnancy rate of their partners, and still a 45% less pregnancy rate in the females than in the group who had not taken the SEX RESPECT course.(see appendix C)

Those who oppose abstinence education often counter with: "Some kids are going to do it anyway; what are you going to do for them?"

In answer to this, the statistical results were increasingly significant.

In the attitudinal study there was an 80% decrease in the number of students who agreed with this statement before vs. after the course: "If someone wanted to have sex with me I probably wouldn't say anything and just let it happen."

This attitude was proven to be reality in the reduction of sexual activity. In a study of high school students who have taken SEX RESPECT compared to the control group, a study done one year later reported the largest difference of 40% more who remained virgins . . . was in the group of students who tested out as having the lowest values from the onset of the study. (see appendix D)

When divided into variables, the amount of birth control information was also significant to an increase in the number of students losing their virginity. The highest transition rate from virgin to non-virgin (23%) was in those who had reported as having received MUCH information on contraception outside of the course, only 10% who had no information of contraception decided to have sex. Therefore, virgins with more information about contraception are more likely to lose their virginity than virgins with no information on birth control. (see appendix E)

The study interestingly showed that the low-mid values group is not only receptive and responsive to the abstinence message in SEX RESPECT in the short run, but that some influence on behavior is much more notable in the long run than with other typical sex education programs that emphasize sexual knowledge at the expense of the important dimensions of human relationships that are taught in the SEX RESPECT Program.

The virgin to non-virgin transference rate was lowest in students taking SEX RESPECT compared to the next leading abstinence programs. Another program in the study which is abstinence-based but gives complete information on birth control, actually showed a higher rate of virgin to non-virgin transference than the control group. Numbers were as follows: Control group 33% lost virginity one year later, SEX RESPECT students 24.7%, Values and Choices 37.7%. (see appendix F)

Obviously, many kids AREN'T going to do it anyway when they learn the truth about love and respect.

If this 9% decrease was translated into dollars, of the 25 billion spent on supporting teen pregnancy, we could save over 2 billion dollars.That is, if all you care about is money, and granted, that is your job if you're on the Appropriations Committee.

But my job is to be an educator, and I really care about the teens. After successfully educating teens about SEX RESPECT, I was asked to share my experiences with others in the form of the SEX RESPECT Program. It is now available to anyone who wants to know the healthy truth about love and sex. (see appendix G) There is no politics involved. The bottom line is, the SEX RESPECT Program helps teens and parents, and helps reduce teen sexual activity. It's widespread rippling effect can positively influence our society. What do you want to invest in? Stop-gap measures which mis-educate people and perpetuate a problem, or the beginning of a long term solution which promotes good health?

Your request for this report asked, "What can the government do?" My suggestions are:

1. Provide special funding to those schools who commit to properly implementing the SEX RESPECT Program. It includes staff training, classroom instruction, and the parental component. When taught properly, it is the top program in the world for reducing sexual activity rates among teens. Schools lacking funds try to put together their own programs which are not as effective. You have standards for their building insulation, boiler safety, and fire prevention. Why not use the best when teaching about love and human sexuality? No other program comes close to SEX RESPECT in the effectiveness of reducing teen sexual activity and teaching positive, healthy attitudes toward love and sex . . . so why try to re-invent the wheel?

2. Quit wasting money on birth control, abortion education and services for teens. They are helping no one in the short term or the long run.

3. Call off the dogs! Organizations such as Planned Parenthood and the ACLU who have a political agenda way outside of health education are trying to interfere with proper sexual health education taking place by nitpicking legal attacks. Planned Parenthood is an organization whose purpose is to promote the use of birth control and abortion. It is unfortunate that they have led people to believe that they are experts in Health, Sexuality or Education. In their own literature they have stated that they do not like the idea of teaching abstinence to teens. Allow those

school districts that freely choose the SEX RESPECT Program to do so without harassment.

4. Do what you can do about the erotic and self-centered sexual information that comes across the airwaves and print media under the disguise of entertainment. This, being much of our children's sex education, only brings out the basal instincts of the sexes, rather than educating a generation in other-centered love, concern and compassion.

5. Publicly, through education, we must keep focused on the preventative health needs of our children and the reality of their emotional need to learn true love and commitment. We must give them proper information and motivation to save sex for marriage, not allowing the latest fads within political correctness to blind us from the truth about sex and love.

APPENDIX A

WHY NOT TEACH BIRTH CONTROL?

This question is asked repeatedly until reasoning and statistics are supplied. When teens are taught contraception in the classroom, they are led to believe that this is a legitimate option for them. We don't instruct in Driver's Education on "how to speed without getting caught" or "how to get traffic tickets fixed." Since sex outside of marriage is not healthy for the teens in our classes, why offer them advice on "how to do it?" The mind of a young adolescent is still operating on a concrete level. Besides giving a double message to someone who needs a single message, teaching birth control will not solve the problems resulting from teen sexual activity:

--- Birth control education has not reduced teen pregnancy or abortion rates.

--- Single women under 18 who use birth control pills to prevent pregnancy have an 11% failure rate.[1]

--- Teenagers who use the pill with a high rate of compliance reported an 18% pregnancy rate within the first year of use.[2]

--- The average combined pregnancy rate for teens using various types of contraceptives with a high rate of compliance is 9.9% to 13% annually.[3]

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[1] William Grady, et al, "Contraceptive Failure in the United States - estimates from the 1982 National Survey of Family Growth," Family Planning Perspective, (Sept/Oct 1986) pp.200-207 (as cited - Dinah Richard #107)

[2] Martin Fisher, et al, "Comparative Analysis of the Effectiveness of the Diaphragm and Birth Control Pill During the First Year of use Among Suburban Adolescents," Journal of Adolescent Health Care, Sept 1987, p. 393.

[3] Melvin Zelnik and John F. Kantner, "Sexual Activity, Contraceptive Use and Pregnancy among Metropolitan Area Teenagers 1971-1979," Family Planning Perspectives Sept/Oct 1980, p. 236.

--- 81% of physicians surveyed agree that the availability of contraceptives has led to increased promiscuity among teens.[4]

--- Teens who have been given birth control education have a 50% higher sexual activity rate than teens who have not. [5]

--- Birth control addresses only one symptom of the problem of teen sexual activity.

--- Birth control does not improve illiteracy or lack of educational motivation, two main characteristics of poor teens who have babies.

--- Birth control does not address teenage loneliness, insecurity and need for intimacy.

--- Many tax-payers oppose birth control instruction in the public schools as an infringement of their religious beliefs.

--- Sexual abstinence is the only certain method of avoiding teen pregnancy.

--- Birth control education for teens weakens the message of abstinence.

--- It gives a double message of "how to say no" and "how to say yes" to an age group that needs only clear guide-lines.

--- Most birth control methods offer little or no protection from sexually transmitted diseases.

--- Birth control for teens contributes to confusion between a perceived need for sex and the true need to love and be loved.

--- 50% of women who have had abortions say that they were using birth control and it failed.

--- Birth control does not stop the emotional bonding that joins the young man and woman during genital activity.

--Break-ups are more devastating for the teens.
--Their ability to bond later to a spouse is hindered.
--Infidelity becomes easier.
--Memories of past sex acts are recalled later and used to make comparisons.

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[4] A. Pietropinto, " A Survey on Contraception Analysis," Medical Aspects of Human Sexuality, May 1987, p. 147

[5] Louis Harris and Associates, " American Teens Speak: Sex, Myths, TV and Birth Control," Harris and Associates for Planned Parenthood Federation of America, Inc., p. 53, 1986.

--Genital bonding can fool young people into marrying the wrong person.

--- Teen sexual activity, even with birth control, can prolong an unhealthy infatuation that should have ended sooner.

--- Birth control does not relieve the guilt, doubt, disappointment and fear of being used that many teens experience in sex outside of marriage.

--- Birth control is not a substitute for self-control.

--- Objective policy makers looking at the history of family planning for teens will probably agree with one of the foremost population control experts, Professor Kingsley Davis of Zero Population Growth, who says:

> **The current belief that illegitimacy will be reduced if teenage girls are given an effective contraceptive is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline while trusting some technological device to extricate society while contraceptive use was becoming more, rather than less, widespread and respectable.**

The truth is that by offering contraceptives to teens, adults enjoy the illusion that they are taking effective action against the rising number of illegitimate births among teens. Like the bull in a bullfight who spends all his energy attacking the matador's cape until the bull, weakened by repeated spear wounds from his actual enemy, receives the final, fatal blow, the concerned adults in our society have been distracted from the root of the problem by the babies being born to unmarried teens. They are spending a great deal of time, talent, energy, and money to eliminate these babies. But the real enemy, uncontrolled sexual desire, is not being addressed. In fact, contraceptives apparently encourage sexual activity by offering some limited protection against the consequence of pregnancy. Meanwhile, our society is being wounded by the "spears" of death, disease, guilt, mental illness, sexual boredom in marriage, immaturity, lack of commitment, abortion, and social breakdown. Contraception is not the answer for sex education because illegitimate births are not the only problem faced by our sexually active teens.

Further, contraceptives reinforce the idea that adolescents are no better than animals, compelled to mate whenever they feel the sexual urge. By giving contraceptives to teens, adults are telling them that although abstinence is by far the best choice, teens probably won't be able to control themselves and therefore need contraceptives. Ironically, teens have responded to that implied message; there has been an increase in both abortions and illegitimate births since contraceptives have become widely available. **The sad lesson many teens have learned is that sexual gratification, even when it is experienced repeatedly, is not the same as sexual fulfilment.** Contraception, technology's despairing answer to adolescent sexual activity, has intensified the loneliness, frustration, and emptiness of our young people. Their anguish can be seen in the alarming statistics on drug and alcohol abuse,

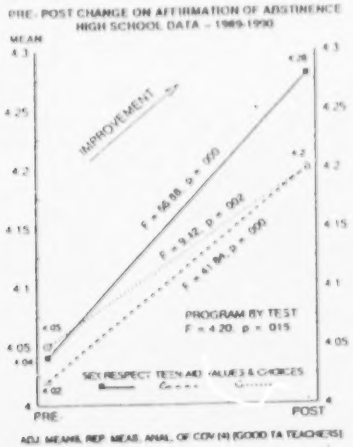
pregnancy, sexually transmitted disease, abortion, and suicide among teens. Contraceptives are no substitute for the difficult and costly work of teaching adolescents to be responsible adults capable of making moral choices. Thus, the SEX RESPECT program offers schools an alternative to sex education that teaches contraception.

(from SEX RESPECT: The Option of True Sexual Freedom Teacher Manual pp.10-12)

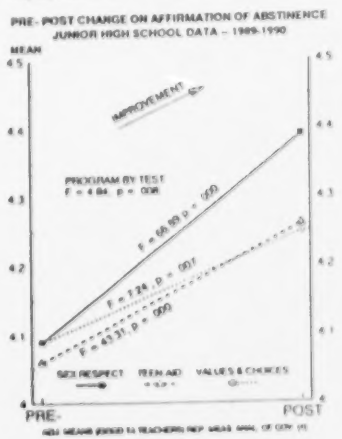
Prepared by THE INSTITUTE FOR RESEARCH AND EVALUATION

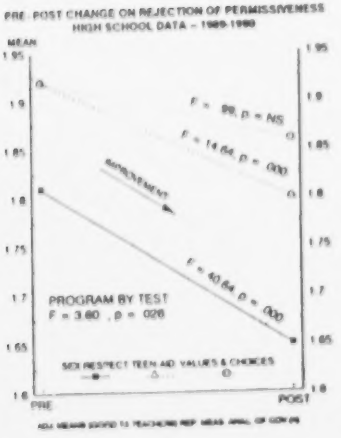
(APPENDIX B)

Program comparison on Affirmation of Abstinence, 10th grade


PRE- POST CHANGE ON AFFIRMATION OF ABSTINENCE
HIGH SCHOOL DATA – 1989-1990
MEAN
IMPROVEMENT
F = 56.88, p = .000
F = 9.42, p = .002
F = 41.84, p = .000
PROGRAM BY TEST
F = 4.20, p = .015
SEX RESPECT TEEN AID VALUES & CHOICES
PRE
POST
ADJ. MEANS, REP. MEAS. ANAL. OF COV (4) (GOOD TA TEACHERS)

Program comparison on Affirmation of Abstinence, Jr. High


PRE- POST CHANGE ON AFFIRMATION OF ABSTINENCE
JUNIOR HIGH SCHOOL DATA – 1989-1990
MEAN
IMPROVEMENT
PROGRAM BY TEST
F = 4.84, p = .008
F = 56.99 p = .000
F = 7.24, p = .007
F = 43.31, p = .000
SEX RESPECT TEEN AID VALUES & CHOICES
PRE-
POST


PRE- POST CHANGE ON REJECTION OF PERMISSIVENESS
HIGH SCHOOL DATA – 1989-1990
MEAN
F = .99, p = NS
F = 14.64, p = .000
IMPROVEMENT
F = 40.64, p = .000
PROGRAM BY TEST
F = 3.60, p = .028
SEX RESPECT TEEN AID VALUES & CHOICES
PRE
POST

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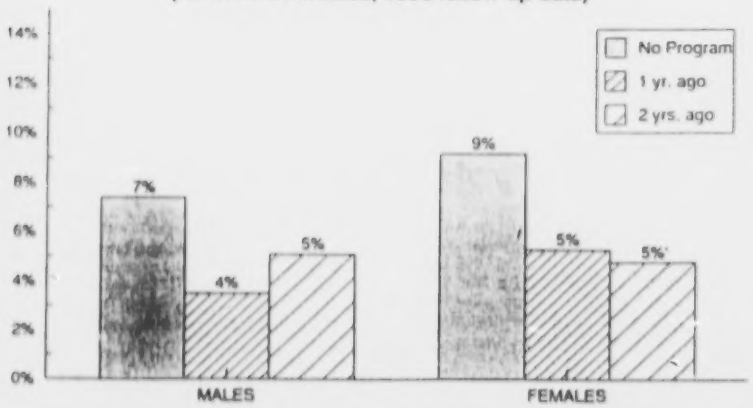
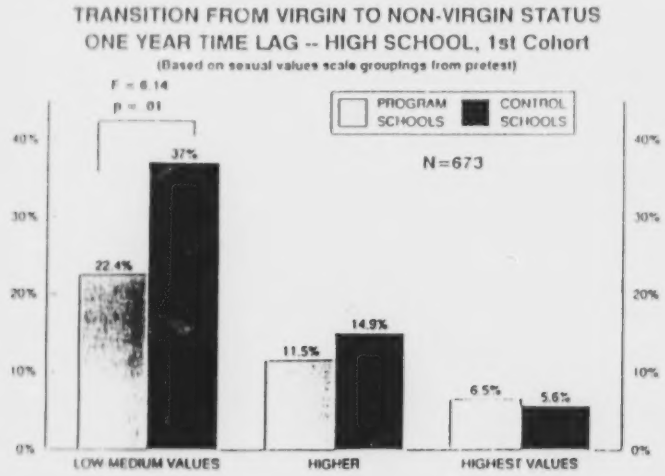
(APPENDIX C)

Comparison of pregnancy rates for program and non-program students.



(APPENDIX D)

Transition from Virgin to Non-Virgin Status, program vs control by value grouping, High school students, one Year Time Lag.



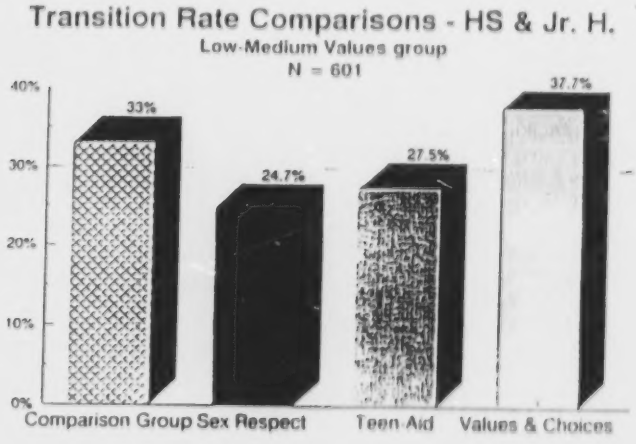
(APPENDIX E)

Transition rates by alcohol use and birth control information and access

Demographic subgroups	# Virgins at pretest	# Transition	% Transition
Drunk			
Never drunk	2630	269	10.2%
Ever drunk	329	96	29.2%
Recently drunk	93	33	35.5%
Birth control information received			
None	2178	235	10.8%
Some	455	75	16.5%
Much	360	83	23.1%
Birth control access difficulty			
Easy to get	1364	184	13.5%
Hard to get	1584	202	12.8%

(APPENDIX F)

Transition rates by program for Low-Medium Values Group



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(APPENDIX G)

RESPECT INCORPORATED

P.O. BOX 349
BRADLEY, IL 60915-0349
815/932-8389

Qty.	Item	Order	Price	Total $
	Sex Respect Student Workbook	0401	8.95	
	Sex Respect Teacher Manual	0402	12.95	
	Sex Respect Parent Guidebook	0403	8.95	
	Sex Respect Promo Video	0405	22.50	
	Intro Package (above four)	0406	49.95	
	Set of Four Posters (w/order)	0407	NC	
	Love and Life Student Workbook	0301	8.95	
	Love and Life Parent Guidebook	0302	6.95	
	Love and Life Teacher Manual	0303	11.95	
	Button: I'm Worth Waiting For	0410	1.00	
	Button: Pet Your Dog, Not Your Date	0411	1.00	
	Chastity Challenge Video (VHS) (for Church or Home use)	0412	59.95	
	Creative Dating Book	0413	7.95	
	Friends: For Teens (study/workbook)	0417	10.95	
	Friends: For Teens (guidebook)	0418	5.95	
	Sticker: I'm Worth Waiting For — 100	0415	5.00	
	Saying No To Sex Is Happiness For Teens	0420	1.50	

SHIPPING AND HANDLING	TOTAL	
Each Additional Item	IL, IA, KS, & SD residents	
5-30 Items — $.25 each item	Sales Tax 6.25% if applicable	
Bulk Shipment over 30 items —	Tax Exempt No.	
5% of total value of sale	1-4 Items Shipping	$ 4.50
Continental U.S. ONLY	Add'l S&H over 4 items	
Allow 3-4 weeks for delivery	Amount Enclosed	

STATEMENT OF ROTAN LEE, PRESIDENT, PHILADELPHIA BOARD OF EDUCATION

Senator SPECTER. We now turn to Mr. Rotan Lee, who has been a member of the Board of Education for the School District of Philadelphia since 1989 and has been the president of the Board since 1992. He has a distinguished career as an attorney and is currently a partner in the prominent firm Fox, Rothchild, O'Brien, & Frankle. Mr. Lee is no stranger to Capitol Hill because he worked here as legal counsel to the Small Business Committee in the House of Representatives and as the senior legislative assistant to Congressman Perry Mitchell.

We welcome you here, Mr. Lee, and look forward to your testimony.

Mr. LEE. Thank you. I submitted in writing, Senator. I am very happy to be here.

Senator SPECTER. Mr. Lee, the full text of your statement and all the texts and statements will be included in the record.

Mr. LEE. So I am going to just sort of highlight and talk about some issues briefly and be responsive to questions.

Senator SPECTER. Fine; that would be very much appreciated.

Mr. LEE. The school district of Philadelphia has gathered a goodly repository of data on the subject of adolescent and teenage pregnancy—programs that we have currently implemented, some that are working better than others.

We have taken some very bold initiatives, not the least of which was the promulgation of a resolution, Policy 123, which not only radically addressed the curricula as it related to health and sexual and adolescent-related policy, but also talked about distributing condoms within the public school system.

This is a frightening problem. I have learned, both as a lawyer and as an educator, that there is not one way that does anything under all circumstances. There are a number of pedagogical approaches that probably ought to be taken as it relates to health care education. There are different ways to address the problem of adolescent and teenage pregnancy to young people.

The problems I think differ in differing communities. I think the issues in the urban communities are different than the issues in the rural communities. I think that the statistics will bear that out in many respects. I think there are other underpinnings associated with this problem: Housing, poverty, unemployment, nihilistic behavior brought on by young people who feel that there are no other options available to them because they have seen their parents without options that sexual activity becomes a thing to do, and that the birthing of children almost becomes a kind of reward in the absence of small steps of success.

I have learned, in dealing with the plethora of problems, to try to look at solutions in little steps, and try to keep the programs that work and bring them to scale, being unafraid to try model programs that might be helpful to some groups and perhaps may have very little application to others.

Probably one out of every five children in this country today lives in a state of poverty in some form or another. That is like 20 percent of the population of children in this country. And although I am very reserved about statistics. As Mark Twain once said, "There are three kinds of prevarication: Lies, damn lies, and statistics." I am always very careful about whose statistic is better than someone else's.

But if that is an umbrella statistic, then under that umbrella perhaps as many as two out of every five Latino children live in a state of poverty, and perhaps as many as one out of two, particularly in urban America, African-American children lives in a state of poverty. Poverty drives teenage pregnancy in urban America. I am absolutely convinced of that.

The one thing I am also convinced of is that there is an inextricable relationship between education and health care. And, as we de-

velop a radical approach to changing how we teach young people to change the way in which we are readying this next generation for Workforce 2000, we have to pay very careful attention to health care. Adolescent and teenage pregnancy is a health care issue. AIDS and sexually transmitted disease is a health care issue. Violence is a health care issue.

And when we build curricula today, we have to build curricula that not only addresses that which we believe to be intellectually based, but that which we believe also to be health care oriented. Someone once defined health as the complete state of physical and mental and social well being, not merely the absence of sickness or infirmity. I think that is a good definition because it not only talks about nutrition, it not only talks about young people taking care of themselves, but it also talks about the mental attitude necessary to live in a very, very difficult environment and an effort to overcome very difficult sets of circumstances.

So, as we teach, we have to teach the mind, but we also have to teach people how to take care of their bodies in every way and under all circumstances.

I am more than happy to be responsive to any of the questions involving programs in the school district of Philadelphia, those programs that are also linking with infrastructure, which is my last point. I am absolutely convinced that there is no educational system today that can effectively work without a linking within the infrastructure.

PREPARED STATEMENT

The ability of that educational system to interact with the delivery of services by other government, whether or not it is children's services and family services, to health care services, is not only the best way to aggregate those services, but it is also a cost-effective way so that we can save money and use those savings to do other kinds of things. Because we have adequately found out how to get the best bang for our buck in all respects of the delivery of education and health and human services.

Senator SPECTER. Thank you very much, Mr. Lee.

[The statement follows:]

STATEMENT OF ROTAN E. LEE

An ambitious agenda of education reform has been initiated in Philadelphia. On December 13, 1993, the Board of Education unanimously resolved to achieve student outcomes by the replication of successful curriculum and instructional models. Initiatives such as clusters of schools, schools within schools and community schools would provide children and adults of all ages with access to a variety of services. Significant among these is access to health education and health care as fundamental requirements for children to enter school ready to learn and experience success in their classrooms.

The School District of Philadelphia is challenged by all the issues impacting on every one of our great city school districts. A fact sheet presenting demographic data is presented in Appendix A.

The current enrollment of 207,667 students is 78% minority, and over the past decade, the demographics of Philadelphia's schools have changed to reflect the steady stream of immigrants from Southeast Asia and the continued flight of the middle class.

Fifty-two percent of our students are from families receiving Aid to Families with Dependent Children (AFDC), 81,157 are eligible for Chapter I services and 46% of our children are from single parent families. Adolescent pregnancy is a persistent issue.

Data compiled by The Research Department of the Family Planning Council of Southeast Pennsylvania indicated an increase in the rate of pregnancy among teenagers in Philadelphia form 1983 to 1992 (Appendix B). The greatest increase in rate, 24.68% was observed among 15 to 17 year olds followed by 12.37% among 18 to 19 year olds and 2.48% among 10-14 year olds. In 1991, 8331 pregnancies were recorded among school age young women from 10 to 18 years of age. These data present an issue of significant impact on the community.

Teen pregnancy is associated with a number of serious problems. Pregnant teens often lack adequate prenatal care and are more likely to deliver low birth weight babies, babies with birth defects and illness. Children of teen parents are at greater risk of lower intellectual and academic achievement, behavior problems and ultimately of becoming teen parents themselves. Teen mothers are more likely to be high school dropouts than those who delay childbearing.

One recent national study found that only 54.5% of the women who give birth before the age of 18 later graduated from high school compared to 95.5% percent of those who delayed their first birth until their mid to late twenties.

Women who have their first child as teenagers earn lower hourly wages, acquire less work experience, and are more likely to live in poverty than women who delay childbirth. These are compelling reasons to develop and support a comprehensive coordinated program of education and health services to prevent teen pregnancy and support pregnant and parenting teens.

The following have been identified as risk factors for teen pregnancy:

- socially isolated
- economically disadvantaged
- parental apathy/lack of interest or involvement
- family/parent history of low school achievement
- teenage parent(s)
- history of sibling retention
- sibling(s) receiving Chapter I or other special services
- alcohol/drug abuse
- early signs of developmental delay or behavioral abnormalities

- abuse/neglect (history or suspected)
- home/environmental deprivation
- family dysfunction/mental/emotional disorder
- limited knowledge of parenting skills
- low birth weight
- history of medical fragility
- family/parental history of aggressive or felonious behavior
- poor attendance in school

For twenty five years the School District of Philadelphia has addressed the issue of teen pregnancy. In 1971 a program was designed to allow young women who became pregnant to continue their education. As knowledge of risk factors and effective interventions evolved, services expanded to include many school based initiatives supported by community linkages and partnerships. Goals and objectives of teen pregnancy interventions include:

- enabling pregnant and parenting teens to continue their education without interruption
- preventing a second unplanned pregnancy
- learning parenting skills
- accessing health care for mother and child
- learning job skills to achieve economic self-sufficiency.

A compendium of programs and services for pregnant and parenting teens are presented and described in Appendix C.

A number of community-based and government agencies, businesses, advocacy groups, and health care providers have substantial links with many of the school programs and are critical to their success. Children's Hospital of Philadelphia, Child Guidance Center, St. Christopher's Hospital for Children, Einstein Medical Center, Greater Philadelphia Health Action, Covenant House Health Services, Graduate Health Systems, Medical College of Pennsylvania, Coordinating Office for Drug and Alcohol Programs, Office of Mental Health, the Philadelphia Department of Public Health, Scott Paper, Family Planning Council SE/PA, Maternity Care Coalition, Junior League of Philadelphia, Inc., Private Industry Council, Fels Foundation, Mercy Health Plan, Independence Blue Cross of Philadelphia, Healthy Start, and Zeta Phi Beta a service organization are among the stakeholders that have joined with the School District in addressing the issue of teen pregnancy. A list of stakeholders linked with schools and school programs is presented in Appendix D.

Simon Gratz High School has been successful in incorporating a range of programs and services into their core academic program. The services were designed to support the needs of the students consitituting the Simon Gratz High School community. The range of services available at Simon Gratz and the linkages with community providers is presented in Appendix E.

While programs and services for pregnant and parenting teens in Philadelphia may be exemplary, they are not sufficient to reach the total population of pregnant and parenting teens. It is estimated that these programs have capacity to serve only one third of those in need of these services. Significantly, the national repeat pregnancy rate for teens is about 18%. The repeat pregnancy rate for teens affiliated with a variety of teen pregnancy programs in Philadelphia is about 4.9%.

Fifty percent of students enrolled in Philadelphia teen pregnancy programs receive prenatal care in the first trimester of pregnancy, and a significant decrease in low birth-weight babies has been observed. Additionally, two-thirds of these students continue their education within three weeks of delivery. These compelling data support expansion of effective programs, and particularly programs that emphasize prevention of teen pregnancy.

We believe that prevention of teen pregnancy is accomplished through comprehensive skills-based health education from kindergarten to grade twelve. Effective prevention education programs that target teen pregnancy emphasize communication skills, problem solving, goal setting, stress reduction, accessing health services, and coping with peer pressure. Effective education programs are comprehensive, are sequential from kindergarten to twelfth grade, and are integrated into the core curricula.

The primary focus of pregnancy prevention curricula is to delay or postpone sexual intercourse by emphasizing abstinence and making responsible choices. A list of curricula approved for use in the School District of Philadelphia is presented in Appendix F .

Implementation of comprehensive health education curricula that include effective pregnancy prevention education requires expanding well beyond teaching health classes the traditional one instructional period per week in middle schools and daily for two semesters in high school. Extensive resources are needed for staff training and the acquisition of instructional materials. Parent and community involvement are essential components of successful programs.

We know, however, that the best educational programs will not accomplish their goals if children come to school unready to learn. That includes being in good health. It is axiomatic that children with unmet

81-864 O - 94 - 6

health needs, who have bleeding gums or who need glasses, cannot benefit to the fullest extent of their potential from the educational program. All too often, unmet health needs begin the cycle of poor academic achievement, leading to low self esteem, leading to other adverse outcomes, including teen pregnancy.

School nurses are the "front line soldiers" in our efforts to achieve access to quality health care for all children, but we do not have nurses in every school, and even where we do, access to health care remains problematic for many children and families.

For such children and families, school based primary health care, in the form of clinics within the schools, offers perhaps the best solution. The Philadelphia School District was first in Pennsylvania to open a clinic in a school , at our Benjamin Franklin High School. That was in 1986, and that clinic is still operating, serving about three quarters of the students enrolled. We now have a total of seven such clinics, augmenting the work of school nurses with twelve more in various stages of planning.

The commitment to enhance comprehensive health education in Philadelphia is supported by Board of Education Policy 123: Adolescent Sexuality and by the School Health Advisory Council chaired by Board Member Dr. Christine Torres-Matrullo. The goal of the Advisory Council is to ensure a coordinated and comprehensive approach to addressing the health issues confronting youth and their families, and is linked with an action plan for educational reform.

Implementation of reform efforts will require expansion of the following effective components of health care and health education. Costs were estimated based on existing programs. Costs stated for school-based health clinic are average start-up costs. The clinics will operate independent of the School District operating budget once established.

Expansion of School-Based Health Clinics (includes mental health services) add 27 @ $250,000	$ 6,750,000
Staff Training to Implement Comprehensive Health Education Including materials @ $ 1,000 for approximately 6,000 teachers	$ 6,000,000
Expansion of Comprehension Services for School Age Parents (School-based)	$ 1,500,000
Expansion of day care services for school-age parents to 10 additional schools @ $ 100,000	$ 1,000,000
Expansion of Drug & Alcohol Services to Pregnant & Parenting Teens (teen male parents)	$ 50,000

Funding for implementation of health care and health education will be sought from a variety of sources including grants, foundation money, and money from business and industry.

The medical, social and economic impact of teen pregnancy on our communities must not be ignored. Resources spent wisely on prevention of teen pregnancy and support to pregnant and parenting teens will accrue to the common good. Investing in our young people and their children will benefit our society by expanding opportunities for our young people and their children to reach their potential for self-sufficiency and for leading healthy productive lives.

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Appendix A

Demographic Backround

SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF ACCOUNTABILITY AND ASSESSMENT

Fact Sheet - Demographic Backround

The 1990 Census revealed that, compared to 1980, the City of Philadelphia as a whole experienced a 16% gain in adjusted income, but residents living in our Chapter 1 schools' neighborhoods experienced a 15% decline in adjusted income - a discrepancy of 31 percentage points. This decrease in income in our Chapter 1 schools' neighborhoods has resulted in an increase in our poverty indicators to hte extent that

* 52% of our children come from families receiving AFDC;

* 78% of our children are eligible for the free or reduced lunch program;

* 46% of our children are from single parent families.

The impact of this level of poverty on children entering our schools has been extreme:

* 25% of our first graders do not attend kindergarten;

* On the DEVELOPMENTAL SKILLS CHECKLIST (CTB-McGraw/Hill) administered in kindergarten 84% of the children score below the national 50th percentile rank in both the Memory and Mathematics subtests, used for Chapter 1 eligibility and evaluation respectivily;

* Almost one-third of the Head Start participants have been found to be developmentally delayed on the School District's Developmental Behavior Checklist.

Over the past decade the demographics of our schools have changed to reflect the steady stream of immigrants from Southeast Asia and the continued flight of the middle class. The net effect has been an increase of 5,000 in the number of Asian children, an increase of 4,000 Hispanic children, a decrease of 8,000 African-American children and a decrease of 15,000 white children. This has meant a dramatic increase in the need for ESOL/Bilingual programs in our schools.

Not only has our school-age population been changing, but it has also been growing recently; projections have revealed a continued increase in the forseeable future. Most of this growth is occurring in our poorest neighborhoods, resulting in extreme overcrowding in their schools.

Appendix B

Live Births and Live Birth Rates

PHILADELPHIA COUNTY

TABLE 8C-Live Births and Live Birth Rates: All Ages: 1983-1992

Live Births

	10-14	15-17	18-19	20-24	25-29	30-34	35-44	TOTAL
1983	164	1,876	2,789	7,932	7,346	3,753	1,319	25,179
1984	120	1,710	2,646	7,715	7,497	3,956	1,314	24,960
1985	159	1,919	2,760	8,206	7,933	4,212	1,470	26,659
1986	159	1,978	2,887	8,527	8,161	4,603	1,669	27,984
1987	171	2,025	2,684	8,497	8,375	4,938	1,799	28,489
1988	177	2,088	2,892	8,391	8,356	5,083	1,887	28,874
1989	198	2,066	2,998	8,393	8,306	5,244	2,032	29,227
1990	212	1,985	2,910	8,369	8,526	5,487	2,206	29,695
1991	221	2,003	2,868	8,153	8,026	5,363	2,421	29,055
1992	228	2,101	2,538	7,845	7,477	5,358	2,479	28,029

Live Birth Rate *

	10-14	15-17	18-19	20-24	25-29	30-34	35-44	TOTAL
1983	2.91	47.50	97.10	98.56	95.35	58.98	13.33	58.64
1984	2.22	44.50	95.78	97.19	95.97	61.53	12.97	56.33
1985	3.05	51.52	104.13	104.82	99.71	63.25	13.91	59.77
1986	3.09	55.40	112.44	112.04	104.03	67.93	15.41	63.09
1987	3.34	58.22	104.70	114.76	109.31	71.03	16.13	64.27
1988	3.48	62.22	113.10	116.14	110.82	71.36	16.46	65.10
1989	3.72	63.15	121.63	120.12	111.99	71.97	17.25	66.04
1990	4.27	67.66	119.64	121.56	117.89	78.17	19.55	69.46
1991	4.53	65.55	128.00	124.05	112.98	76.73	21.21	68.77
1992	4.75	72.80	120.35	126.84	103.94	74.84	21.08	67.51

* Rate of Live Births per 1000 females.

These data were supplied by the State Health Data Center, Pennsylvania Department of Health, Harrisburg, Pennsylvania. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.

Compiled by:
The Research Department
Family Planning Council of SE/PA
(215) 985-2622

Appendix C

Programs and Services for Pregnant and Parenting Teens

Programs and Services for Pregnant and Parenting Teens in the School District of Philadelphia

Adult Literacy Classes

Adult Basic Education (ABE) and General Educational Development (GED) classes are available to out-of-school youth over the age of seventeen to enable them to complete their education via an alternative education path. Classes are available at teen parent centers such as the Comprehensive Services for School Age Parents Program, and throughout the city at selected libraries, community centers, and evening schools..

Funding: Pennsylvania Department of Education and School District of Philadelphia

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Community Integrated Services System (Home Health Visiting)

Four Home Health Visitors under the general supervision of a social worker provide services to pregnant and parenting teens in the area of accessing appropriate health care for themselves and their children. This demonstration project receives referrals from School District nurses, counselors, hospitals , clinics, social service agencies, community organizations and teens themselves.

Funding: United States Department of Health and Human Services.

Comprehensive Services for School Age Parents Program (CSSAP)

Working primarily with pregnant rather than with parenting students, CSSAP enables pregnant teenagers to continue their education in an alternative educational setting. Through a team effort involving teachers, social workers, and the school nurse, students are encouraged to remain in school, to establish and maintain a pre-natal and post-partum health plan, and to learn parenting skills.

Funding: School District of Philadelphia

Day Care

Day care specifically set aside for the children of pregnant and parenting teens who are AFDC eligible is available at the Comprehensive Services for School Age Parents program and several comprehensive high schools. A social worker facilitates Department of Welfare payments and assists teen parents who aren't eligible for those benefits in identifying other day care services.

Funding: School District of Philadelphia, Pennsylvania Department of Education, Philadelphia County Assistance Office.

Elect I

This program provides a family grouping class for 14-16 year olds who have experienced extended absence from school at an off-school site (CSSAP). Three social workers provide intensive case management to support the young mother in her return to a regular school program. The program is linked to the New Directions Program, a collaborative venture between the County Assistance Office and the Pennsylvania Department of Education. The New Directions Program provides transportation and child care allowances to eligible participants.

Funding: Pennsylvania Department of Education, Pennsylvania Department of Welfare.

Elect II

Teams consisting of a social worker, a school-community coordinator and an educational advisor provide services to pregnant and parenting teens at three Philadelphia high schools, William Penn, Gratz, and Benjamin Franklin High Schools, and seek to re-

enroll students who have dropped out of school or to improve the attendance of those who do not attend on a regular basis. Each team seeks to re-enroll at least 20 stu ½ nts in school.

Funding: Cities in Schools, Pennsylvania Department of Education, Pennsylvania Department of Welfare.

Health Education

The standardized health education curriculum, kindergarten through high school, is the foundation for health instruction within the School District. It is a comprehensive curriculum which includes developmentally appropriate, planned, and sequential instruction about health in various content areas, including human sexuality education. A primary objective of the middle and senior high school sexuality unit is to delay or postpone sexual intercourse, and the senior high school curriculum includes a unit on parenting. Collaborations with such organizations as the Philadelphia Department of Public Health, Planned Parenthood and the Family Planning Council of Southeastern Pennsylvania provide topic specific staff development training and student classroom programs.

Funding: School District of Philadelphia, U.S. Department of Health and Human Services.

Health Services

School nurses and other health professionals provide an array of services from screenings to referrals, from health counseling to health care access, designed to insure the health of individual children. In addition, the establishment of school-based health centers has meant providing primary health care, including diagnostic and treatment services, in schools. To date, there are seven such centers located at two high schools, two middle schools, and three elementary schools, with another twelve in various stages of planning.

Funding: School District of Philadelphia, Foundations, Pennsylvania Department of Health and various health resources.

New Choices at West Philadelphia High School

This is a sixty hour employability program offered at one local high school for adult single parents and/or displaced homemakers. It includes individual and group counseling sessions, services referrals and follow-up, and special workshops and presentations.

Funding: Pennsylvania Department of Education.

Overbrook High School Drop Through Prevention Initiative

The purpose of this initiative is to provide programs at Overbrook High School facilitated by the school nurses which support pregnant and parenting teens in continuing their education with as few interruptions as possible. Additionally, it includes programs for accessing and maintaining pre-natal care and post-partum follow-up as well as

workshops in parenting skills, prevention of disease and subsequent pregnancies, and healthy living practices. In order to meet its goals, several agencies, e.g., Maternity Care Coalition and The Junior League of Philadelphia, Inc. are linked with the high school to provide services to these students.

Funding: Maternity Care Coalition, Junior League of Philadelphia, Inc., and Family and Parenting Center at the Philadelphia College of Osteopathic Medicine..

Parents as Teachers

The goal of the Parents as Teachers program is to involve parents in the process of teaching their children from birth. Located at the Teen Parent Centers at West Philadelphia and Martin Luther King High Schools, Parent Educators work with young parents one-on-one in their homes and through group sessions at the student's school. The parent educators deliver a child development curriculum developed by the National Institute for Parents as Educators, but are also available to make needed social, health, housing, and educational referrals.

Funding: School District of Philadelphia, Pennsylvania Department of Education, Scott Paper Foundation, Fels Foundation, Mercy Health Plan, Blue Cross, and the United States Department of Education

Pregnancy - It's Not for Me

Housed at Gratz High School and Sayre Middle School, this educational awareness program focuses on pregnancy prevention through various media. Students are involved in hands-on projects such as creating posters and writing essays to inform their peers of the desirability of delaying early parenthood,

Funding: Student Support Services, School District of Philadelphia

Perkins Single Teen Parent Program

A social worker paired with a school community coordinator will be placed at two area vocational-technical schools and one comprehensive high school to support pregnant and parenting teens in approved vocational education programs. They will monitor student performance and provide workshops in addition to making social service referrals.

Funding: Pennsylvania Department of Education.

Teenage Pregnancy Intervention Program

This program provides intervention services to pregnant and parenting teens, male and female, who use or abuse drugs. In addition, the issue of violence is addressed as it relates to relationships and a strong emphasis is placed on supporting young people throughout their high school endeavors. Programmatic linkages with such agencies as the Philadelphia Housing Authority, WIC, Maternal and Infant Care, etc. are extensive

Funding: Philadelphia Department of Public Health

Appendix D

School Community Support Agencies and Personnel (Stake Holders)

Schools with Health Resource Centers and the Sponsoring Health Care Agency (October 1993)

SCHOOL	HEALTH AGENCY
Bartram High School	Greater Philadelphia Health Action
Ben Franklin High School	Greater Philadelphia Health Action
** Central High School	Einstein Medical Center
** Edison High School	St. Christopher's Hospital
** Gratz High School	Medical College of Pennsylvania
** Martin Luther King High	Covenant House Health Services
** Lamberton High School	City Line Hospital of Graduate Health Systems
Overbrook High School	Spectrum Health Services
** West Philadelphia High School	Child Guidance Center
** University City High School	Children's Hospital of Philadelphia

** These seven sites contributed data to the analyses in this report for the School Year 1992-1993.

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Provide comprehensive job development and referral/ placement services which ensure that financially needy New Choices clients secure and retain employment to enable economic independence. Four employers must be targeted by program staff during each program year for intensive job development/placement.

The employers who will be targeted by program staff will include:

Pep Boys 32nd Street and Allegheny Avenue
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(215) 227-9022
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Vice-President Human Resources

Philadelphia Zoological Gardens
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Philadelphia, PA
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Contact: Constance Poole
Human Resources Manager

Insurance Society of Philadelphia
456 Public Ledger Building
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Contact: Mariellen Whelan, Ph. D.
President

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Contact: Ronald Gilg
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Contact: Tamika Pearson
Human Resources Manager

Appendix E

Simon Gratz High School Teen Parenting Program

Simon Gratz High School
Teen Parenting Program
Elect II Program

Mission: To provide a program for pregnant and parenting teens that addresses the needs of students through academic counseling, access to social services, nutrition and health referrals, human growth and development and parenting skills.

We have identified three groups of students at Gratz High School:

Group I: Pregnant Teens
Group II: Parenting Teens
Group III: Retrieved Parenting Teens

The following programs and services are available to all students at different stages of development in the above mentioned categories:

Prenatal counseling and referrals are provided by the school nurse practitioner.

Prenatal counseling and examinations are provided by the Medical College of Pennsylvania through a health care partnership.

Woman and Infant Care Program (WIC) through the WIC Mobile provides nutrition information and access to healthy and nutritious foods for both mother and child.

Comprehensive Services for School Age Parents (CSSAP) located at Temple University is offered to pregnant teens who wish to attend an alternative program during pregnancy. Referrals are made through the social worker in the Elect II Program.

Elect II Program provides services to the above mentioned groups through an educational advisor, school community coordinator and social worker.

Comprehensive Day Care Services offers day care for a limited amount of children on the premises. This center is fully staffed and provides an appropriate educational environment for children from 8 weeks-3 years and their parents.

Human Growth and Development and Parent Participation are required of students that bring their children to the Day Care Center.

Health Resource Center is available on a walk-in basis for contraceptive information and counseling information for teen fathers.

Weekly classes for pregnant and parenting teens on values clarification, drug and alcohol counseling, mediation training, and sexuality issues are provided by the Drug Prevention Specialist from the Rites of Passage Program.

The Family Planning Counsel of Pa. has developed a program entitled "Pregnancy, It's Not for Me". This program provides a variety of activities that educate on sexuality issues with particular emphasis on the prevention of first and second pregnancies.

The Outreach Program and Trunk Show from the Please Touch Museum offers free visits and memberships to parents to encourage learning through creative play with their children.

Read Together is a program provided by a grant from the Chapter One Program to encourage grandparents, parents and children to share in the reading of books and poetry.

Classes on family planning and contraceptive education provided by the Family Planning Clinics from Medical College of Pennsylvania and Temple University.

Infant and Child CPR certification is offered to all Elect II staff and selected staff members from the Day Care Center

Appendix F

Health Education Curricula

SCHOOL DISTRICT OF PHILADELPHIA

STUDENT SERVICES
OFFICE OF CURRICULUM AND INSTRUCTIONAL SUPPORT

HEALTH EDUCATION CURRICULA THAT SUPPORT POLICY #123

School District of Philadelphia Standardized Health Education K-4, 5-8, 10-11

The standardized health education curriculum is the foundation for health instruction within the School District. It is a comprehensive curriculum which includes developmentally appropriate, planned, sequential instruction about health in ten content areas. It provides students with knowledge and skills to make health-promoting decisions that focus on preventing disease and maintaining and improving health.

Reducing the Risk: Building Skills to Prevent Pregnancy, STD and HIV

The Reducing the Risk curriculum is a skills-based curriculum that contains seventeen lessons designed to help students develop the skills they need to support abstinence and resist unprotected sex. This curriculum is being used in middle schools (grade 8).

ETR Associates 1993

Entering Adulthood: Coping with Sexual Pressures

This curriculum is a skills-based curriculum that contains seven lessons designed to promote abstinence by providing students with essential skills in sexual decision-making. The curriculum is used in grades 9-12 to augment the standardized health curriculum.

Contemporary Health Series, ETR 1989

Into Adolescence: Choosing Abstinence

This curriculum is a skills-based curriculum that contains seven lessons designed to promote sexual abstinence by providing students with essential communication skills to resist pressures to engage in sexual activity. The curriculum is used in grades 6-8 to augment the standardized health curriculum.

Contemporary Health Series, ETR 1989

Teenage Health Teaching Modules (THTM)

THTM is a comprehensive skills-based health education curriculum consisting of six modules covering topics such as Violence Prevention, Preventing AIDS and Other STDs, Strengthening Relationships with Family and Friends, Living with Feelings, and Tobacco, Alcohol and Drugs. The THTM curriculum is the curriculum of choice as the core health education curriculum for high school students. By June, 1994, it will replace the School District of Philadelphia Standardized Health Education curriculum.

STATEMENT OF ROSETTA STITH, Ph.D., DIRECTOR, LAURENCE G. PAQUIN SCHOOL

Senator SPECTER. I will be coming back to questions after we have heard from Dr. Rosetta Stith, who is the director of the Laurence G. Paquin School for expectant adolescents and parenting teenagers in Baltimore. She has a distinguished career as an educator and has been an elementary teacher, reading specialist, and middle and secondary school principle. She received her doctoral degree from Temple University and also holds a master's degree from Johns Hopkins and a degree from Oregon State University.

Welcome, Dr. Stith, and we look forward to your testimony.

Dr. STITH. Well, first, I would like to thank you all for inviting me. I am impressed. I am impressed because, after listening to two distinguished presenters, we are on the right track.

As director of the Paquin School, I live with this issue every day. As the vice chair for Maryland's welfare reform, we are advocating and developing some pilot programs that will work based on what we know this generation is not doing. I would like to share with you some of my observations on the needs that I think need to be put into place for children if you are going to see change, and that is the importance of early intervention and prevention programs for children and youth. In essence, do it while it helps, instead of later while it hurts.

The Paquin School provides inter-generational programs which serve the entire family. The inclusion of our on-site Family Medicine Health Center has had a tremendous impact and has created a positive social acceptance, because when you are taught experience and observe the importance of health as it relates age appropriately to our physical and mental wellbeing, children, adolescents, and teens are less likely to do those negative social behaviors which would knowingly harm them or their babies.

Thus, the word "no" becomes an operational word, synonymous to "abstain," because it is easier not to do something when the action goes against your health and, in some instances, will result in the death of a child, an adolescent, teen, or young adult. Consequently, children and teens will see the need to abstain and to not participate in drugs, alcohol, and substance abuse, and unprotected sexual activities, crime, and violence, because negative activities will have a devastating effect upon their lives and families.

You asked the question: What are we doing to curb the incidence of pregnancies among minor mothers? Paquin provides realistic and age-appropriate intergenerational programs which stress prevention and abstinence because we know that by the age of 17, most adolescent females have engaged in sexual activity. By the age of 15, many have experience with an illegal drug or substance, and statistics have increased among adolescents age 10 to 14 years of age.

I also have a middle school. My school is now middle-secondary, meaning I have sixth grade girls who are pregnant. We are talking about 11 and 12 year olds, not 17 year olds. The reality for those of us who are in the trenches is that the lack of such schooling programs, especially in urban cities, continues to have a devastating impact upon adolescent school populations.

Its impact for in-school male and females: A drop in middle school and high school attendance; an escalation of violence; the use of crack cocaine instead of heroine, which creates another birth defect to deal with; unintentional pregnancies among this population has skyrocketed; STD's have reached an epidemic level for this population; sexual, physical, and mental abuse have increased among children and adolescents.

Unfortunately, when any or most of these happen to our youth and their children, we tend to abandon them. I am, however, hoping that our presence and testimony this morning will help you to understand that if we are looking to change tomorrow for our children, we must begin today with age-appropriate programs which meet the needs and work for them at this point in their lives.

What works for adolescents? We have found that providing school-linked services with agencies that already service this population does not create a new money expenditure but redirects money already allocated and targeted to schools which already service the population but have no additional funding to provide needed services and in-school programs.

The inclusion of age-appropriate health education with emphasis on physical circumstance, as well as providing mental health support for the mother, her child, the baby's father, and other family members, as needed on-site, has had a tremendous impact and difference and a noted impact for our population. Specifically, this approach has enabled our students to realize and feel the consequences of what happens when you live irresponsibly, regardless of what is not happening to them or for them at home.

Through age-appropriate health activities and experiences, adolescents learn to empower themselves, take control of their lives, make better decisions, and gain better independent judgment. Adolescents learn that they too are important, have self-esteem and rights like everyone else when carried out in a respectful manner.

Age-appropriate health curriculums helps adolescents to realistically understand how their bodies work, why and when, at what age, and for what. They learn what helps and what hurts them and, in some urban communities, what will kill them, and most importantly, what will keep them strong and healthy, and who they should see when they are not, which makes the words "options versus consequences" realistic and meaningful.

As caring adults and professionals, our task for solution: We should begin to mentor these kids like our own and show them that we care; to age-appropriately begin to talk about human sexuality to address their curiosity and answer their questions. This approach is preferable to ignorance.

If not age-appropriately explained to adolescents, both misconceptions will lead to pregnancy and possible contraction of the AIDS virus. This is disheartening, particularly with the fact that, with the rates that are as high as they are among adolescents, AIDS and HIV education is still not offered in all secondary schools. That is why we stress the importance of early intervention and prevention programs today, instead of later when it hurts.

Ladies and gentlemen, Paquin knows the concerns but goes directly to the students to hear the needs, because there can no longer be a one size fits all approach to education. If you want

something to fit and work, you must cut your garment according to the cloth. We take the mall approach to services for students, meaning that all needed services are provided on-site with special emphasis on Thursday, which is a family service day.

Our program has helped young women, and very soon will do the same thing for our young men with our Teen Father's Responsibility Program to help them understand the need to abstain until they have completed high school or college and are economically self-sufficient, help to love and educate their children as soon as they are born. Education and health will continue to be our youth's stabilizer and the keys for successful and healthful living.

The program will help them understand the need to strengthen and maintain family; help the young father to be responsible, productive, and to refrain from having other children; and understand that life is not only important but also expensive, and should not be a desirable or practical option if you are an adolescent.

In order to help them we must stop using our family models, expectations, and values for this population whose lives are dramatically different from our own. It is possible to move this generation's mindset to a mind change by controlling what children see on television. They feel the need to replicate whatever they see. Kids must see to be.

So we need to provide more positive mentoring and role modeling programs and activities for them; provide more positive age-appropriate programs which will foster and promote self-esteem, character, and responsibility; provide more funding for family support centers and in-school health centers which will respond to the continual health needs of adolescents, which will help to eliminate separate bureaucracies that teens have problems with; eliminate hours of travel for service; provide age-appropriate information and consequences about drugs and substance abuse; provide referral services for WIC and employment, talking about jobs, career development, and social services, child care, well baby services, transportation, a hotline; and, most importantly, do not dismiss their calls for help, because adolescents will ask questions and argue but they are going to expect an answer.

In 1994, we should not have homelessness, but it does exist. We should not have poverty, crime, violence, drug abuse, injustices, discrimination, or teen pregnancy, but we do. They all exist because of what has not happened in someone's life, especially that of a child.

You must ask yourself why all of a sudden we have so many depressing social problems. The answer is the world has changed, even as of yesterday. No 2 days are alike or predictable. People today are as different as the fingers that are on my hand. And because they are, we too must change and prepare ourselves and our children to meet the challenges of tomorrow head on and to learn to become faster, smarter, today.

Kids may tell us to go away, but what they are really saying to us is, "If you care about me, you will not go far." Tomorrow's world belongs to this next generation, and without early intervention, prevention, and focused age-appropriate health care programs for children and adolescents, tomorrow for them will still be the same. Progress is made when everyone moves in the same direction. The

same applies to resolutions for this problem if we expect the tree to bloom again.

PREPARED STATEMENT

We know that the problems of our Nation's youth is a national concern because of its human and economic costs to society. To save this generation and their children from self-destruction, we must take our heads out of the sand and deal with it early and age-appropriately, and move them from an associated consumption of resources to a collective consumption of resources if we want to save them, meaning that day care, early learning intervention, and prevention programs pays for tomorrow.

The bottom line is we need to take the assumption away from what should be happening for children and put into place what needs to be, because if we do not begin today, we will have no tomorrows without them.

Thank you.

[The statement follows:]

STATEMENT OF ROSETTA STITH

SENATORS SPECTOR AND HARKIN AND OTHER MEMBERS OF THE APPROPRIATIONS COMMITTEE.

GOOD MORNING. I AM DR. ROSETTA STITH, DIRECTOR OF THE LAURENCE PAQUIN SCHOOL FOR EXPECTANT AND PARENTING ADOLESCENTS. THE PAQUIN SCHOOL PROVIDES INTERGENERATIONAL PROGRAMS WHICH SERVES THE ENTIRE FAMILY. THE INCLUSION OF OUR ON-SITE FAMILY MEDICINE HEALTH CENTER HAS HAD A TREMENDOUS IMPACT AND HAS CREATED A POSITIVE AND SOCIAL ACCEPTANCE BECAUSE WHEN YOU ARE TAUGHT, EXPERIENCE AND OBSERVE THE IMPORTANCE OF HEALTH AS IT RELATES, AGE-APPROPRIATELY TO OUR PHYSICAL AND MENTAL WELL BEING, CHILDREN, ADOLESCENTS, AND TEENS ARE LESS LIKELY TO DO THOSE NEGATIVE SOCIAL BEHAVIORS WHICH WOULD KNOWINGLY HARM THEM OR THEIR BABIES. THUS, THE WORD 'NO' BECOMES AN OPERATIONAL WORD SYNONOMOUS TO ABSTAIN BECAUSE IT IS EASIER NOT TO DO SOMETHING WHEN THE ACTION GOES AGAINST YOUR HEALTH, AND IN SOME INSTANCES, WILL RESULT IN THE DEATH OF A CHILD, ADOLESCENT, TEEN, OR YOUNG ADULT. CONSEQUENTLY, CHILDREN AND TEENS WILL SEE THE NEED TO ABSTAIN AND NOT TO PARTICIPATE IN DRUGS, ALCOHOL, SUBSTANCE ABUSE, UNPROTECTED SEXUAL ACTIVITIES, CRIME AND VIOLENCE BECAUSE SUCH NEGATIVE ACTIVITIES WILL HAVE A DEVASTATING EFFECT UPON THEIR LIVES AND FAMILIES.

YOU ASK THE QUESTION, "WHAT ARE WE DOING TO CURB THE INCIDENCE OF PREGNANCIES AMONG MINOR MOTHERS?' PAQUIN PROVIDES REALISTIC AND AGE-APPROPRIATE/INTERGENERATIONAL PROGRAMS WHICH STRESS PREVENTION AND ABSTINANCE BECAUSE WE KNOW THAT:

.By the age of 17, .most adolescent females have engaged in sexual activities.

.By the age of 15, many have experimented with an illegal drug or substance.

.Statistics have increased among adolescents aged 10-14 years

THE REALITY FOR THOSE OF US IN THE TRENCHES KNOW THAT THE LACK OF SUCH SCHOOL LINKED PROGRAMS, ESPECIALLY IN OUR URBAN CITIES, CONTINUES TO HAVE A DEVASTATING IMPACT UPON OUR (ADOLESCENT) SCHOOL POPULATIONS, SUCH AS:

It's impact for in school male and female parents:

. A drop in middle and high school attendance

- Escalation of violence
- The use of crack cocaine instead of heroin, thus creating another birth defect to deal with
- Unintentional pregnancies among this population skyrocketed
- STD's reached epidemic levels for this population
- Sexual, physical, and mental abuse increased among children and adolescents.

UNFORTUNATELY, WHEN ANY OR MOST OF THESE THINGS HAPPEN TO OUR YOUTH, AND THEIR CHILDREN, WE TEND TO ABANDON THEM. I AM, HOWVER, HOPING THAT OUR PRESENCE AND TESTIMONY THIS MORNING WILL HELP YOU TO UNDERSTAND THAT IF WE ARE LOOKING TO CHANGE TOMORROW FOR OUR CHILDREN, WE MUST BEGIN TODAY WITH AGE-APPROPRIATE PROGRAMS WHICH MEET THEIR NEEDS AND WORKS FOR THEM AT THIS POINT IN THEIR LIVES.

WHAT WORKS FOR ADOLESCENTS? WE HAVE FOUND THAT PROVIDING SCHOOL-LINKED SERVICES WITH AGENCIES THAT ALREADY SERVICE THIS POPULATION DOES NOT CREATE NEW MONIES EXPENDITURES, BUT REDIRECTS MONEY ALREADY ALLOCATED/TARGETED TO SCHOOLS WHICH ALREADY SERVICE THE POPULATION BUT HAVE NO ADDITIONAL FUNDING TO PROVIDE NEEDED SERVICES AND IN-SCHOOL PROGRAMS. THE INCLUSION OF AGE-APPROPRIATE HEALTH EDUCATION, WITH EMPHASIS ON THE PHYSICAL CIRCUMSTANCE, AS WELL AS PROVIDING MENTAL HEALTH SUPPORT FOR THE MOTHER, HER CHILD, THE BABY'S FATHER, AND OTHER FAMILY MEMBERS AS NEEDED, ON-SITE, HAS MADE A TREMENDOUS DIFFERENCE AND A NOTED IMPACT. SPECIFICALLY, THIS APPROACH HAS ENABLED OUR STUDENTS TO REALIZE AND FEEL THE CONSEQUENCES OF WHAT HAPPENS WHEN YOU LIVE IRRESPONSIBLY IRREGARDLESS OF WHAT IS NOT HAPPENING TO THEM OR FOR THEM AT HOME.

.THROUGH AGE-APPROPRIATE HEALTH ACTIVITIES AND EXPERIENCES, ADOLESCENTS LEARN TO EMPOWER THEMSELVES, TAKE CONTROL OF THEIR LIVES, MAKE BETTER DECISIONS, AND GAIN BETTER INDEPENDENT JUDGEMENT.

.ADOLESCENTS LEARN THAT THEY TOO, ARE IMPORTANT, HAVE SELF-ESTEEM, AND RIGHTS LIKE EVERYONE ELSE, WHEN CARRIED OUT IN A RESPECTFUL MANNER.

.AGE-APPROPRIATE HEALTH CURRICULUMS HELPS ADOLESCENTS TO REALISTICALLY UNDERSTAND HOW THEIR BODIES WORK, WHY AND WHEN, AT WHAT AGE, AND FOR WHAT. THEY LEARN WHAT HELPS AND HURTS THEM.

AND IN SOME URBAN COMMUNITIES, WHAT WILL KILL THEM, AND MOST IMPORTANTLY, WHAT WILL KEEP THEM STRONG AND HEALTHY, AND WHO THEY SHOULD SEE WHEN THEY ARE NOT, WHICH MAKES THE WORDS, 'OPTIONS VERSUS CONSEQUENCES' REALISTIC AND MEANINGFUL.

AS PROFESSIONALS, OUR TASK FOR RESOLUTION:

. WE MUST BEGIN TO MENTOR THESE KIDS LIKE OUR OWN, AND SHOW THEM THAT WE CARE.

. AGE-APPROPRIATELY BEGIN TO TALK ABOUT HUMAN SEXUALITY, TO ADDRESS THEIR CURIOSITIES, AND ANSWER THEIR QUESTIONS. THIS APPROACH IS PREFERABLE TO IGNORANCE.

IF NOT AGE-APPROPRIATELY EXPLAINED TO ADOLESCENTS, BOTH MISCONCEPTIONS WILL LEAD TO PREGNANCY AND THE POSSIBLE CONTRACTION OF THE AIDS VIRUS. THAT IS DISHEARTENING IN THE FACT THAT WITH RATES THIS HIGH AMONG ADOLESCENTS, AIDS/HIV EDUCATION IS STILL NOT OFFERED IN ALL SECONDARY SCHOOLS. THAT'S WHY WE STRESSED THE IMPORTANCE OF EARLY INTERVENTION AND PREVENTION PROGRAMS TODAY, INSTEAD OF LATER WHEN IT HURTS.

LADIES AND GENTLEMEN, PAQUIN KNOWS THE CONCERNS, BUT GOES DIRECTLY TO ITS STUDENTS TO HEAR THE NEEDS, BECAUSE THEIR CAN NO LONGER BE A 'ONE SIZE FITS ALL' APPROACH TO EDUCATION. IF YOU WANT SOMETHING TO FIT AND WORK, YOU MUST 'CUT YOUR GARMENT ACCORDING TO YOUR CLOTH'. THUS, WE TAKE THE 'MALL APPROACH' TO SERVICES FOR OUR STUDENTS, MEANING THAT ALL NEEDED SERVICES ARE PROVIDED ON-SITE WITH A SPECIAL EMPHASIS ON THURSDAY, AS 'FAMILY SERVICE DAY'.

OUR PROGRAM HAS HELPED YOUNG WOMEN AND, VERY SOON, WILL DO THE SAME FOR OUR YOUNG MEN WITH OUR "YOUNG FATHER'S RESPONSIBILITY PROGRAM, TO UNDERSTAND THE NEED TO:

. Abstain until they have completed high school/college and are economically self-sufficient

. Help to love and educate their children as soon as they are born. Education and health are and will continue to be our youth's stabilizer and keys for successful and healthful living.

. Strengthen and maintain family

. Help the young father to be responsible, productive, and to refrain from having other children.

. Understand that life is not only important, but also expensive and should not be a desirable and pratical option if you are an adolescent.

IN ORDER TO HELP THEM, WE MUST:

. Stop using our family models, expectations, and values for this population whose own lives are dramatically different from our own.

IT IS POSSIBLE TO MOVE THIS GENERATION'S MIND SET TO A MIND CHANGE BY:

. Controlling what children see on television. They feel the need to replicate whatever they see. Kids must see to be. Provide more positive mentoring and role modeling programs and activities;

.Provide more positive age-appropriate programs which will foster and promote self-esteem, character, and responsibility.

.Provide more funding for family support centers and in-school health centers which will respond to their continual health needs and adolescents

. Eliminate separate bureaucracies that teens have problems with

. Eliminate hours of travel for service

. Provide age-appropriate information and consequences about drugs and substance abuse

. Provide referral services for WIC and employment (jobs, career counseling, and social services)

. Child care, well baby services

. Transportation . Hotline

. Do not dismiss their calls for help, because adolescents will ask questions, argue, expect answers

IN 1994, WE SHOULD NOT HAVE:

. HOMELESSNESS, IF DOES EXIST

. WE SHOULD NOT HAVE POVERTY, CRIME, VIOLENCE, DRUG ABUSE, INJUSTICES, DISCRIMINATION, OR TEEN PREGENCY, BUT WE DO

THEY ALL EXIST BECAUSE OF WHAT HAS NOT HAPPENED IN SOMEONE'S LIFE, ESPECIALLY, THAT OF A CHILD. YOU MIGHT ASK YOURSELF, WHY ALL OF A SUDDEN, WE HAVE SO MANY DEPRESSING SOCIAL PROBLEMS? THE ANSWER. THE WORLD HAS CHANGED, EVEN AS OF YESTERDAY. NO TWO DAYS ARE ALIKE, OR PREDICTABLE. PEOPLE TODAY ARE AS DIFFERENT AS THESE FIVE FINGERS YOU SEE ON MY HAND: AND BECAUSE THEY ARE, WE TOO MUST CHANGE, AND PREPARE OURSELVES AND OUR CHILDREN TO MEET THE CHALLENGES OF TOMORROW HEAD ON AND TO LEARN TO BECOME SMARTER, FASTER, TODAY.

KIDS MAY TELL US TO GO AWAY - WHAT THEY REALLY MEAN IS, 'IF YOU CARE ABOUT ME, DON'T GO TOO FAR. TOMORROW'S WORLD BELONGS TO THIS NEXT GENERATION. WITHOUT A EARLY INTERVENTION/PREVENTION AND FOCUSED AGE-APPROPRIATE HEALTH CARE PROGRAM FOR CHILDREN AND ADOLESCENTS, TOMORROW FOR THEM WILL STILL BE THE SAME. PROGRESS IS MADE WHEN EVERYONE MOVES IN THE SAME DIRECTION, THE SAME APPLIES TO RESOLUTIONS FOR THIS PROBLEM IF WE EXPECT THE TREE TO BLOOM AGAIN.

WE KNOW THE PROBLEMS OF OUR NATION'S YOUTH IS A NATIONAL CONCERN BECAUSE OF ITS HUMAN AND ECONOMIC COSTS TO SOCIETY. TO SAVE THIS GENERATION AND THEIR CHILDREN FROM SELF-DESTRUCTION, WE MUST TAKE OUR HEADS OUT OF THE SAND - AND DEAL WITH THEM EARLY, AND AGE-APPROPRIATELY AND MOVE FROM 'AN ASSOCIATED CONSUMPTION OF RESOURCES TO A COLLECTIVE CONSUMPTION OF RESOURCES IF WE WANT TO SAVE THEM. MEANING THAT DAY CARE, EARLY LEARNING INTERVENTION AND PREVENTION PROGRAMS PAYS FOR TOMORROW.

LADIES and GENTLEMEN - WE MUST BEGIN TODAY - BECAUSE WE HAVE NO TOMORROW'S WITHOUT THEM.

THANK YOU.

Senator SPECTER. Thank you very much, Dr. Stith. Senator Gorton had to go on to another hearing but has asked me to submit a statement for the record from Ms. LeAnna Benn, National Director of Teen Aid, Inc., which we will include at the conclusion of the testimony.

I would like to call attention to the charts which have been prepared by our able staff, chart 1 showing that between 1986 and 1991 the rate of births to teenagers 15 to 19 rose 11.9 percent from slightly over 50 percent to roughly 62 births per 1,000 females. The U.S. teen birth rate is more than double the rate of teens aged 15 to 19 in Canada and Australia. France and Japan report the lowest rates of teen births with 9 and 4 births per 1,000, respectively, in the 15 to 19 bracket.

Charts 3 and 4 show the dramatic increase in births to unmarried females since 1980, with unmarried birth rates rising 21 percent over this period of time.

Mr. Lee, let me begin with the comment that you made about condoms in public schools and ask you what your policies are in the school district of Philadelphia with respect to distribution of condoms.

Mr. LEE. We are in the high schools. I hasten to add not in the middle schools, which we ought to be in the middle schools, and not in the elementary schools, and I hope we never get to the elementary schools. But we freely provide condoms to students in the high

schools unless they are prohibited from receiving condoms through parent determination.

Senator SPECTER. Do you advise the parents of the availability of condoms in the absence of an express parental declination?

Mr. LEE. We do.

Senator SPECTER. How many declinations do you get, roughly?

Mr. LEE. Not many; probably under 15 percent.

Senator SPECTER. What is your response to the concerns expressed that the availability of condoms will increase sexual promiscuity?

Mr. LEE. I disagree with that notion absolutely. I consider this issue of teenage pregnancy, sexually transmitted disease, including AIDS, a health care issue. I think that the use of condoms is an apparatus, among others, to deal with this issue.

We do not dispense condoms in an isolated way. There is a very comprehensive adolescent and sexual curriculum.

Senator SPECTER. Does your curriculum include a heavy emphasis on abstinence?

Mr. LEE. The foundation of the curriculum is abstinence. And also, the interaction with young people who come to obtain the condoms is a foundation based in abstinence in terms of guidance by those who are providing the condoms.

Senator SPECTER. Do you have any statistics or figures which show the difference in requests between males and females?

Mr. LEE. Yes; we do. I think that some of that is included in the body of the testimony. We have been accumulating that data over the last year more comprehensively. I will be happy to provide you with the most recent data when I return.

We are unable—I hasten to add this, too, because this is a hard statistic to get—to determine what the success rate is, how efficacious the program is, in fact, in terms of providing young people with condoms. Am I able to draw a direct link to a reduction in teenage pregnancy or a reduction in AIDS and sexually transmitted diseases? I do not have that statistic.

Senator SPECTER. Do you think that you will be able to come up with meaningful statistics along that line?

Mr. LEE. Well, we are trying to develop a matrix or matrices to be able to address that issue in terms of the number of young people who have come in to get condoms versus those persons—and this is all voluntary I might add—who would talk about the frequency of their sex versus the frequency of their sex with and without protection.

These statistics are very, very hard to get, and one of the reasons that these kinds of programs are so easily targeted by many people who believe that what the school district of Philadelphia is doing, and similarly situated school districts, is an intrusion into parental prerogatives. It is very difficult to provide some statistical predicates to get people to believe that condom distribution, along with comprehensive health care curricula, as well as strong guidance, really has a positive impact on the reduction of teenage pregnancy, sexually transmitted disease, and AIDS.

Senator SPECTER. When you say that you have it for high schools but not for junior high schools but you suggest that you should

have it for junior high schools, what standards do you apply to limit it to the high schools?

Mr. LEE. It is purely and emphatically and unquestionably a political issue. It has really nothing to do with whether or not condoms ought to be distributed to middle schools, because I believe they ought to. And I certainly think Dr. Stith has made it very clear that this problem has found itself in adolescents, into the sixth grade.

Senator SPECTER. Dr. Stith, what do you think about the distribution of condoms?

Dr. STITH. As far as the distribution of condoms is concerned, I do not agree with anything that is just distributed to children.

Senator SPECTER. I am sorry; I did not hear that. You do not agree with anything what?

Dr. STITH. I do not agree with things that just are distributed without the proper knowledge and education. In other words, there should be a founding place for them, and that is why we have the family center. We have moved from a school-based clinic to a Family Medicine Health Center so that kids will understand, from a health point of view, if you need this, it is here.

But I think there needs to be some type of instruction or a base where kids can go, because I know in some places this happens and you are just handing it out. And consequences occur with that because kids are kids and do not know what to do with it.

Senator SPECTER. But when you talk about pregnancy with an 11-year-old child, would you suggest that condoms be distributed to that age student?

Dr. STITH. No; we need to get to their parents. We need to get into the home.

Senator SPECTER. How do we do that?

Dr. STITH. Well, through the agencies that serve. And now we are moving into schooling services, and a part of the suggestions that we are making, that we made for the welfare reform, was for those agencies which serve the parents, because the schools basically serve the kids. We have a hard time getting to the parents. Our parents were adults; their parents are older children. So those social agencies need to go into that home.

I have a problem, since I was an elementary school teacher, with why someone 10 or 11 is pregnant. I have a problem with that. It means there is a breakdown in what is happening in that home. Something is not happening. No; you do not need a condom. No; she does not need one. The home needs someone to go in there and put into place those practices, values that need to be there, so that this youngster should not have to even think about a condom or other than being a 10-year-old.

Senator SPECTER. Let me turn to the question which is being debated broadly on Capitol Hill today and, as I say, really across the Nation, and ask you first, Ms. Mast, what your sense of the legislative policy ought to be with respect to welfare payments.

Do you think that if the welfare system was substantially revised that it could be structured in a way to cut down on teenage pregnancies, children born out of wedlock where welfare payments are made?

Ms. MAST. That is really a good question.

Senator SPECTER. This is obviously a very sensitive subject but it is one which we are talking about really on Capitol Hill. People are talking about cutting back on payments for the second or third child, giving discretion to the States. There is already talk about litigation on that subject, big debates about whether it is an inducement for teenage pregnancy for teenage children. And when we have the experts here, I would like to know your view and then go straight across the table. What do you think?

Ms. MAST. We do see a lot of numbers of repeat pregnancies with those who had their first pregnancy as a teenager, particularly those that are unmarried. There are some young people who see that ADC check as a ticket out of the house because of their bad home situation. And, as Dr. Stith says, we need to address what is going on first of all in the home.

Another issue that is probably a rather radical idea is that a lot of the charity that the government is involved in right now is maybe something that should be done through the churches rather than—you know, people talk so much about separating church and State. When you see young girls go to a lot of the unwed mothers homes and social service agencies that are run by private organizations that help them and teach them at a personal level, rather than go for Federal aid for that, they see that there is a more personal relationship there, and they seem to get more aid and assistance and help to turn their life around.

So I would say sometimes the public moneys are not necessarily helping or improving the situation.

Senator SPECTER. Mr. Lee, what is your sense as to whether the availability of welfare or the unavailability of welfare might be a disincentive for teenage pregnancies?

Mr. LEE. I certainly am in favor of radical welfare reform and reducing welfare payments as relates to multiple pregnancy. I am absolutely in favor of that.

Senator SPECTER. How about the first pregnancy?

Mr. LEE. No; I am not, because generally the first pregnancy, often the first pregnancy, and I think that Judge Sylvester indicated this, is a very different process, from spontaneity to a young person being overborne with influence by an older person, whether it is an older adult or an older teenager. No; I think that the rule of law of one bite of the apple is equally applicable in teenage pregnancy as it would be to jurisprudence.

But I do think that when you get into this issue of second, third, and fourth pregnancies, you have got a problem. I think that we have to get tough about these issues. I think we have got to be prepared to conceive, plan, and implement tough programs, many with sanctions.

Senator SPECTER. What kind of sanctions?

Mr. LEE. Where we create disincentives, perhaps by the imposition of penalties on parents who are parenting children who are having children.

But I hasten to add that, at the same time we radically reform welfare, we must pay very careful attention to the adequacy of funding of education, because somewhere along the line in order to change the mental state of these young people there has to be an option. And that option is the ability to become a motivated and

productive member of the work force, being able to live in an independent way through an independent means.

In order to do that, we must be certain that this country adequately funds education, which I do not believe that we do. So, as we reform welfare, perhaps from welfare savings, through reformation of welfare, that we turn that money over to a more comprehensive and adequate funding-oriented approach to education.

I realize for someone who clearly is a liberal that my statements may be harsh. But the poet William Wadsworth Longfellow said, "Give us for our abstractions solid facts, and for our disputes, plain pictures." We need some very solid facts dealing with very solid facts and very plain pictures to deal with a problem that is not going to go away and a problem that must not be met because we believe it is not going to go away so that, as opposed to treating the illness, we simply continue to treat the symptomology.

Senator SPECTER. One final question. What do you say to those who say that you are punishing the innocent additional child?

Mr. LEE. I cannot really answer that because there is no good answer where someone could not say that the second pregnancy or the third pregnancy results in a punishment. To some degree, that is true. I mean it is true. But what we are trying to do is to stem a problem in a very short period so that it does not become a problem in perpetuity. So it is sort of like dealing with an issue of pain for a short period of time in order to eliminate the pain thereafter.

But education, economic development, and other issues have to be inextricably intertwined with the notion of welfare reform. And, as you know, Governor Casey is in the middle of that process as we speak, the whole issue of welfare reformation in the Commonwealth of Pennsylvania. It is one State among many that are looking very circumspectively and very intensely at the burden of welfare on the tax dollar.

We need to reduce that burden and put more of that tax dollar into Workforce 2000, because I think that what is at risk here is the American work force. With the end of this cold war, world power is no longer determined by nuclear arsenals and readiness of a standing army, but the degree of productivity, motivation, and technological orientation of its work force. We have to ready this work force. And in order to do it, we have to put our money into what best readies that process.

Senator SPECTER. Dr. Stith, I would like your insights on this issue as to welfare reform and motivation as we try to understand it, and begin with the specific question: Do you think that there is any substance to what has been suggested by some that if there were no welfare payments that it would discourage teenage pregnancies?

Dr. STITH. Based on my observation and my premise that kids must see to believe, the answer for me would be that many of these youngsters live in dependent communities.

Senator SPECTER. Live in dependent communities?

Dr. STITH. Dependent communities. That is correct. And there tends to be and has been for a long time a generational mindset, and that is what children are seeing. If they do not see anyone paying for anything, they do not even understand the cost of a kid. So it is an attitude, because once something arrives, it is paid for.

They do not seem to understand, because I mean now we are dealing with the fantastic plastic. They are dealing with paper that is not money. That is not the real world. But we are the ones who are paying for that.

As far as reducing welfare payments to be a deterrent, I would have to answer no. Is jail a deterrent for crime? It is not. We still have it. It goes back to the mindset. It goes back to starting early. There tends to be a mindset of what is going to happen. For some, jail is fine. As they say, "I get three hots and a cot. I don't get that. I don't get that at home."

Senator SPECTER. You get what?

Dr. STITH. Three hots and a cot. Three meals, a sheltered place, health care, day care, a place to stay for many. So I would say no.

But then, too, on the other hand, I would agree to a point that poverty is a root problem. But the welfare system is not going to solve that. But then, on the other hand, poverty for them basically translates into lack of opportunities.

Senator SPECTER. When you talk about jail not being a deterrent because we have jails and we still have crimes——

Dr. STITH. That is correct.

Senator SPECTER. The question is, how many crimes would we have without jails. Would we not have more crimes without jails?

Dr. STITH. Well, that is true. And you are absolutely right. In some instances, right now the thinking is build more, since there are more crimes, to put more people in. But you have got to go back and change that mindset in order for you to experience a change.

And as far as girls having more children, that is because no one—silence is consent, and the country is tired of it.

Senator SPECTER. Well, the crime problem is certainly a great deal more complicated than simply three strikes and you're out. That is a subject for another committee and another hearing, and we have spent a lot of time on that. And we are wrestling with this problem as to motivations.

When Mr. Lee, from a progressive school system, identifies himself a liberal and says he is prepared to cut off payments for the second or third unwed delivery, it is food for thought.

Dr. STITH. Yes.

Senator SPECTER. I asked him how he justifies it and he says, well, you have to start somewhere. You have to establish a policy to try to move against a problem. And we are wrestling with it. There obviously is no easy answer, but we really appreciate the experience and judgments which you experts bring to it today.

Dr. STITH. May I add one more statement?

Senator SPECTER. Sure.

Dr. STITH. In terms of the young women who have more than one child, in some it has not happened. It still is not happening. But in order that we do not penalize the child, Maryland is advocating removing those children from those homes so that the parent gets nothing, and putting that child in a managed care situation so that kids can begin to see positive things going on, better health care for those children, and to see that one of the things that they do is to stay in school and be healthy.

Senator SPECTER. Well, that is a suggestion which has been made and draws very adverse reaction in a lot of quarters. We had a Republican Senators' retreat. We went to a big city for the first time in our history, and I was the host Senator. We ended up in a labor hall, the electricians hall. My colleagues had not been in too many labor halls, and then we heard some people from the inner city. The suggestion was made about foster homes. And how far is America prepared to go with managed care homes or foster homes on having the law take away the child from the mother?

Dr. STITH. Let me qualify that. In cases where the mother has been documented as being—a lot of babies have died and have been documented by the mother as being abused. I am not talking about homes, per se. But you do have people who would like to and would not mind taking a child in. That is what we are talking about.

We are not talking about building any more, creating any more, because foster has created another attitude of second standard and really not family. We are talking about people who want to do it, and shifting that money that was given for the care for this kid to someone who wants to do it. I am one who is going to opt for managed care for a couple of my students.

Senator SPECTER. I do not understand that.

Dr. STITH. I said I am going to be one of those persons who will opt as a payee to be a person who will manage the care and direct the care of some of my students who are homeless.

Mr. LEE. I understand what you are saying.

Senator SPECTER. How many can you manage, Dr. Stith?

Dr. STITH. How many can I manage? With the staff that I have, at least 20, and that is not difficult.

Senator SPECTER. That is a good start.

Mr. LEE. If I might make a point, too, about this issue of radical welfare reformation. Most—I will say most and probably I could really say all in my experience—working poor communities are very conservative communities with some very defined rules and regulations, mores, and folkways about how the world works and how they live their lives, and who are very opposed to getting things for free, who want to work, who want to be productive, who have a very negative view toward single parentage and unwanted children and issues of adolescent and teenage pregnancy. And that is either the working black poor, the working Latino poor, the working white poor, the working Asian poor.

I think that if you would ask most of the people in these communities if they had a chance of taking money and redirecting it toward one component of American life, what would that component be for the generation of parents today, including single parents, they would probably not say welfare. They would probably say education.

Senator SPECTER. Ms. Mast, do you have any final comment on this subject?

Ms. MAST. On the welfare reform, I think the key is go back to the family. Again, do what we can do to enable families, looking at marriage is not that bad an idea. People could learn. As we learn to parent, we learn intimacy. Parents depend upon each other. They learn industriousness. They learn that working is a good thing to do. They depend on their love to get themselves

through. And they develop an intimacy through the bonding that is part of the nature of sexual activity to bond with each other to form a stronger family.

If we work back through these educational processes to strengthen that family from the beginning, they will be less dependent on the Government to do those things that they should be doing for each other and with each other.

Senator SPECTER. Thank you.

Mr. Lee, I note from your statement that 50 percent of the students enrolled in Philadelphia teen pregnancy programs receive prenatal care in the first trimester of pregnancy, and a significant decrease in low-birthweight babies has been observed. To the extent that you could give us statistics on that, we would be very grateful.

We are working very hard on trying to make a determination. We have started the Healthy Start Program, which came largely from the experience that I had in Pittsburgh a decade ago when one of the cities—there are eight pilot programs around the country. One is in Philadelphia and one is in Pittsburgh. And, to the extent that you have any statistics there, I would be very appreciative.

Mr. LEE. I will be able to provide that to you.

We have absolutely determined—I come from a family of physicians. My father is a retired surgeon in Philadelphia. And, without a doubt, I mean he said this to me years ago and I believe this today, adequate prenatal and neonatal care is—the benefits of it are just unquestionable. And if you provide that through community school services or school-linked services or linking within the infrastructure, you cannot help but have healthy children.

Senator SPECTER. Well, I have been perplexed why more is not done in America, because while this subject is taboo and very risky and very dangerous to talk about the whole subject, you cannot say that if you are to tell pregnant young women about prenatal care that you are encouraging sexual activity. And it seems to be one of the things we really ought to be doing without any question, but it is being done to a very, very limited extent.

Mr. LEE. Well, there are those who believe that anything intrusive into the parenting process or the life of the parent community or the life of the religious community ultimately fosters the process. And it is a hard sell. As I said earlier, the reason we do not have condoms in the middle schools is not because they do not deserve to be in the middle schools. It is because the politics it too tough to get them into the middle schools.

Senator SPECTER. I am not unaware of some political considerations or talking about condoms at all, especially in the middle schools, or even asking a question about condom availability for 11 year olds. Every time we venture into this subject, it is a matter which draws the ire in a lot of quarters.

Mr. LEE. Absolutely.

Senator SPECTER. People do not want it discussed at all. And it is very difficult not to give some people grounds for misconstruing what you say. But when you talk about prenatal care for pregnant young women the issue comes up that this encroaches upon parental prerogatives or religious prerogatives. It is just a little hard to

see when teenage pregnancies go wrong, and you have the incidence of so many children born who weigh a pound, about the size of my hand, human tragedies and very expensive. I think that is the one area where I am waiting for a defense. Do you have a defense of it, Ms. Mast?

Ms. MAST. I have spent 1,200 hours in a neonatal intensive care unit. In addressing the prenatal care issue, I had a premature baby 2 years ago, and I had tremendous prenatal care. But in the 3½ months I spent with neonatality, observing what was going on around me, I noticed quite a few young, unwed mothers there.

And what I would say is not necessarily as much whether you saw a doctor or not, but I have a whole different view of that from my background in health education and nutrition. One factor is the use of drugs.

Senator SPECTER. Excuse me. Do you know of any justification for not giving information on prenatal care to a young pregnant woman?

Ms. MAST. There is no justification for that. But there is more to it that is necessary. A lot of the problems that lead to toxic pregnancies are malnutrition, the toxins, the pesticides, those things in our environment.

Mr. LEE. The answer is no. There is no defense.

Ms. MAST. So there is no reason why you cannot educate them. But they even need more education than just going to the doctor, is what I am trying to say.

Senator SPECTER. Well, I quite agree with that. Thank you very much, Ms. Mast, Mr. Lee, Dr. Stith.

Dr. STITH. I would like to add that our school has an onsite prenatal Family Medicine Health Center and well baby services, and I do not have an incidence of low birthweight.

Senator SPECTER. Thank you all very much. Thank you.

STATEMENT OF MARKITA MORRIS, STUDENT ADVISORY MEMBER, PHILADELPHIA BOARD OF EDUCATION

Senator SPECTER. I would like now to call our final panel, the teen panel: Ms. Markita Morris, student advisory member of the Philadelphia Board of Education; Ms. Mary Morris, Paquin School for Expectant Teenage Mothers; and Mr. Shawn Braxton, Father's Program, Paquin School for Expectant Teenage Mothers.

Ms. Markita Morris is a senior at Julia Reynolds Masterman High School in Philadelphia, president of the student body, senior class president. Do you have any plans to run for the U.S. Senate?

Ms. MARKITA MORRIS. No; none at all. [Laughter.]

Senator SPECTER. And serves as student advisory member of the Philadelphia School Board. We welcome you here, Ms. Morris, and look forward to your testimony.

Ms. MARKITA MORRIS. Thank you very much. Good morning, Senator Specter.

Senator SPECTER. Thank you.

Ms. MARKITA MORRIS. I am sure you have heard plenty of stories about incidents of teen pregnancy. But I would like to give you some insight of how I avoided teen pregnancy and the support programs and services that have helped me become successful and become a successful student.

I grew up in a neighborhood where there was a lot of teen pregnancies, but I had a strong and supportive family who stressed the importance and the necessity of a good education. I knew that I would let nothing stand in the way of my attaining my goals, and I also realized that childbirth and motherhood were two adult responsibilities that I was not ready for.

I see no great difference between myself and my peers, but I try to express my individuality, independence, and perseverance in all things that I do. I surround myself with positive people, young adults and adults alike, and my friends share my goals and my outlook on life. We realize that we are the future, so we strive toward success and we try to live respectfully and as righteous as possible.

To be a successful student it takes good, old-fashioned hard work and a realization that times have changed. You must use intelligence and common sense in a world in a time that says you will not get ahead. I stress the importance of positive peer pressure and positive influences in life. Success can only be measured by personal standards, and by fulfilling the goals that I have set for myself and becoming a loving, caring human being has made and will make me successful.

The types of school services that have supported me in becoming successful have been extracurricular activities. Outside help from teachers, peer programs, peer counseling, and other activities have been an invaluable part of my success. Growing up in North Philadelphia, track, student government, and other activities have kept me away from the dangers and ills that many of my peers fell into. Also, seeing peers and people slightly older than me who were successful, intelligent, and respecting because they avoided certain avenues of destruction made me strive for that same excellence.

Kids my age feel that there is no way out or that they cannot get ahead. But seeing their peers make it shows them that they can. I am thankful to the Creator that I have been blessed with the knowledge to avoid some of the things other people have to go through. It upsets me when I hear young girls speak of babies as if they were dolls or a status symbol. Young people have to wake up to the fact that making a baby does not make you an adult; it is taking care of one that does.

Most teenagers do not have the skills, maturity or financial security that it takes to raise a child, but we must show them and help them to do so. We have to praise students and young people who avoid drugs, pregnancy, and violence, and we should never be tired of hearing of outstanding students. We should help the ones who fall by the wayside.

PREPARED STATEMENT

If I were to design a peer program, it would focus more on prevention than intervention. We cannot keep using Band-Aids to solve our large problems. This program would serve all age groups, ethnic groups, and students from all types of high schools. I would recruit business and industry, individuals from entertainment, and all kinds of people to help with my program. Peers would do the actual work of counseling, educating, showing students how and

what to avoid. I would also use former drug addicts, ex-convicts, also teen mothers, to help other students know what it is like.

We must understand that when one child is in pain, we all feel it. And the pain should hurt more in our hearts than in our pocketbooks. Thank you.

Senator SPECTER. Thank you very much, Ms. Markita Morris.

[The statement follows:]

STATEMENT OF MARKITA MORRIS

You grew up in a neighborhood where there is a lot of teen pregnancy. Why didn't you fall prey to the same fate as other girls in the neighborhood.

I had a strong and supportive family who stressed the importance and the necessity of a good education. I knew that I would let nothing stand in the way of attaining my goals. I also realized that childbirth and motherhood were two adult responsibilities that I was not ready for.

What makes you different from your peers?

I see no great difference from my peers. I try to express my individuality, independence and perseverance. I surround myself with positive people, young adults and adults alike. My friends share my goals and my outlook on life. We realize that we are the future so we strive towards success and we try to live respectfully and as righteous as possible.

What does it take to be a successful student?

To be a successful student, it takes good old fashioned hard work and a realization that times have changed. You must use intelligence and common sense in a world and a time that says you will not get ahead. I stress the importance of positive peer pressure and positive influences in life. Success can only be measured by personal standards. Fulfilling the goals that I have set for myself and becoming a loving, caring human being has made and will make me successful.

What types of school services supported you in becoming successful?

Extra-curricular activities, outside help from teachers and peer programs have been an invaluable part of my success. Growing up in North Philadelphia, track, student government and other activities kept me away from the dangers and ills that many of my peers fell into. Also seeing peers and people slightly older than me, who were successful, intelligent and respected because they avoided certain avenues of destruction, made me strive for the same excellence many kids my age feel there is no way out, that they can't get ahead, seeing their peers make it, shows them that they can.

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When your friends have babies, how does it make you feel as an African American woman? Do you feel pressure that you are not going through the same things that they're going through?

I am thankful to the Creator that I have been blessed with the knowledge to avoid some of the things other people have to go through. It upsets me when I hear young girls speak of babies as if they were dolls or a status symbol. Young people have to wake up to the fact that making a baby does not make you an adult, it's taking care of one that does. Most teenagers don't have the skills, maturity, or financial security that it takes to raise a child. We have to praise the students and young people who avoid drugs, pregnancy and violence. We should never be tired of hearing from outstanding students and put pressure on those people who have fallen by the wayside.

If you were to design a peer program, what would it look like?

If I were to design a peer program, it would focus more on prevention than intervention. We can't keep using band-aids to solve large problems. This program would serve all age groups, ethnic groups and students from all types of schools, magnet, comprehensive etc.

I would recruit business and industry, individuals from entertainment and use them as advertisement or imitation. Peers would do the actual work of counseling, educating and showing students how and what to avoid in society. I would also use former drug addicts, ex-convicts etc. to demonstrate first hand the negativity in our society.

STATEMENT OF MARY MORRIS, PAQUIN SCHOOL FOR EXPECTANT TEENAGE MOTHERS

Senator SPECTER. We now turn to Ms. Mary Morris. We welcome you here and look forward to your testimony.

Ms. MARY MORRIS. Thank you. Well, I am 17, and I have an 11-month-old daughter. Her name is Cierra. I attended Paquin for 2 years. I plan on going back next year to finish my senior year and then to move on to college.

I didn't really plan on becoming a mother. I was really in school. I went to an academic school and went to Baltimore City College. I was in the school and I had a color guard after school, which meant my time was all taken up. And then when I got around to hanging with one certain boy, which was my boyfriend, I started cutting school all the time. Like my mind just focused off of school and went onto that boy like I would do anything for him.

So then I started cutting school, and that is when I became pregnant. When I became pregnant, my mother's first words was, "You're going to quit school, and I don't want you to." And that's what a lot of society says, is when a girl gets pregnant she'll never amount to nothing. She's just going to quit school, be another person on welfare.

I want to prove them wrong, because since I have had my daughter I have stayed in school the whole time I was pregnant, returned to school after I had her. I don't rely on welfare. I am a working single mother. I mean you can't determine how one person's life is going to be because the rest of the world does that.

I have a lot of friends at Paquin who do work. A lot of my friends are still in school. And I try to help them to stay in school, because a lot of my friends still have problems, too, and I have problems. When I have problems, like if I feel as though I can't go to my mother, I go to Dr. Stith and she is always there with open arms or open ears to help somebody.

It's just real hard being a mother. I never expected motherhood to be as hard as it was. Like she said about baby dolls, you know I figured well, you can dress the baby and take her out all day and, you know come home. But I never thought of how hard it would be, because my daughter stayed sick with ear infections a lot when she was younger, so I was running her back and forth to the doctor's.

She is in the infant center in the school, which is a lot of help. They help me a lot, you know. She started walking early. She started everything early because not just me having time to spend with her, other people were working with her as well as I was.

I guess that if I had the chance to do it over, I don't think—well, I would do it over, but not as young as I did. I would have waited until I knew where I wanted my life to be. You know, I would have had my career started, because I started too young and I realize the mistakes that I made. And now I am just working harder to correct the ones that I made.

Senator SPECTER. Thank you very much, Ms. Mary Morris.

STATEMENT OF SHAWN BRAXTON, FATHERS PROGRAM, PAQUIN SCHOOL FOR EXPECTANT TEENAGE MOTHERS

Senator SPECTER. Mr. Shawn Braxton, thank you for coming. Mr. Braxton is a 22-year-old father of a baby born to a teenage mother and he attends the teenage father's program at Paquin School. The floor is yours.

Mr. BRAXTON. Good morning.

Yes, sir; I'm the father of two. I have a son. I finished high school before I had kids. I am 23 years old, and I plan to stay with the teenage mother of my daughter and help her get her proper schooling if she doesn't get help at home.

I visit Paquin often when I am not working to find out how she is doing, to talk with other students, to see Dr. Stith, ask her how she's doing. And my main concern is that I do not want her to have to rely on welfare or any other type of source, but try to help herself to get a job that she wants to get in life, the proper education, schooling, and try to be more self-aware of her wellbeing.

You know everything that seems nice to you and you see everybody in big fancy cars, dressing nice and everything, didn't come easy. If it came easy, they had to do something for it. Maybe it wasn't right, but they had to so something.

Me, I would say through all my years of going to school, I was more of a comedian. My mother taught me well. She knew I was smart. I just took it as a joke until she said:

You have to grow up one day. You're going to get older; you're going to have to move out. You're going to be a young man. You're going to have kids, and you're going to see just how it is to be responsible.

And I see how it is now. I try to use my mind not to make it to be hard. Once I keep saying it's hard, I can't do it, I can't get up, I can't do this, can't do that, then you get lazy. You keep sitting around waiting from somebody to do something for you, and it's not going to ever come. So I work.

I didn't go to college right away because I wanted to try on my own to see if I could make it ahead, you know, as far as using the education that I have through high school. I do plan to go back to college because I see I need more education. As the years get more further and further, technology is changing, the world is changing in many ways. It doesn't help much. It helps, but it doesn't help much. The cost of living is skyrocketing. Everything just costs a whole lot of money. I can't afford a lot of things.

It doesn't matter where I live. It doesn't matter where I came from. That should never stop me neither. You are still supposed to be able to strive for anything, regardless of where you come from.

The only thing I guess I'm trying to say is a lot of situations with pregnancy, diseases, welfare, money here and money there—the only thing I need to say is there is a lot of help out there, and I would like a lot of people to try and give back to those who need it. That's mainly the way I see it.

Senator SPECTER. Mr. Braxton, do you visit your child?

Mr. BRAXTON. Yes; I do.

Senator SPECTER. Without being unduly personal, I would be interested to know, if you would care to respond, whether you have considered marrying the mother.

Mr. BRAXTON. Yes; I have.

Senator SPECTER. And?

Mr. BRAXTON. We've talked about it. She wants to. I want to. I am at the point now nothing else matters to me. I don't hang out in the streets no more. I don't have a lot of buddies and all that stuff. It's just a lot of back stabbing going on. You think you trust people, and people just falsify theirselves to you with a face. Then you get to know them, and they are not who you expect them to be.

So I am taking it upon myself to try to be more family oriented and try to grow up, as my mother told me to do, and try to provide. With the things that she has been through, I take from that and try to correct and try not to go in that direction.

Senator SPECTER. You are 22?

Mr. BRAXTON. Yes; 22. I will be 23 this coming Saturday. I will be 23 on June 11.

Senator SPECTER. You will be 23 on June 11?

Mr. BRAXTON. Yes.

Senator SPECTER. Well, I was 23 when I got married; 23 may not be too young an age to be married. On June 14, my wife and I will celebrate our 41st wedding anniversary. I hate to be that specific, giving all those statistics. But they are not irrelevant, and for a good cause I would tell a little more than I would choose to. But 23 is not too young to be married, at least from my own personal experiences.

I would be interested in knowing all three of your responses to the approach of abstinence. When we hear the articulation, "say no," is that realistic? Does that have a chance to work? Will young people respond to the moralizing of saying that as a matter of personal values it is wrong to have sex before marriage and abstinence is the best approach?

Ms. Mary Morris, what do you think?

Ms. MARY MORRIS. Well, my mother never—well, I learned about abstinence, and I had a sex education class. But my sex education class never, you know, went around—it was just about the male reproductive system and the women reproductive system.

Senator SPECTER. It never taught you values?

Ms. MARY MORRIS. No.

Senator SPECTER. Saying that it is the wrong thing to do?

Ms. MARY MORRIS. No; I feel you can tell a person, or you could try to teach a person to stay abstinent, but as long as it's peer pressure and with that person being with their friends and having their own mind and determination what they want to do, they're not going to listen to what you say. Because my mother told me, you know, we talked and talked and talked about safe sex and, you know, all the right things to do. But when it was time for me——

Senator SPECTER. Your mother and you talked about safe sex?

Ms. MARY MORRIS. Me and my mother had a very close relationship. But when it came time to me having sex, I was the hardheaded one and didn't use no contraception at all. But, on the other hand, I did go back to my mother and tell my mother. And we went to the doctor. She took me to the doctor's, and we had a talk with the doctor. And it happened that they did take a pregnancy test then and I wasn't pregnant. And my pills were not in, so I had to go back to get my pills. And within the time that I went back, that's when my pregnancy came up.

Senator SPECTER. What do you think about abstinence, Ms. Markita Morris?

Ms. MARKITA MORRIS. I think the teaching of abstinence can be realistic as long as it coincides with teaching about self-awareness, self-esteem, wellness, and also that you will make this choice. No matter how much you get from your parents, how much you get from teachers, administrators, you will have to make that choice to say no, to say yes. If you do say yes, these are the steps you should take to protect yourself, to protect your partner.

I think what happens is all too much we keep focusing on just say no, just say no, just say no. That is great. That is actually what should happen. But we should also say, for those of you who may not say no. But I always stress, my friends and I would always say, positive peer pressure. Positive peer pressure. You don't surround yourself with people who are going to tell you to skip school; you

don't surround yourself with people who are going to tell you to do drugs, because that's not right.

You surround yourself with people who are looking toward the same thing you are, who are about school, who are about an education, who are about college, who are about work. That is what I try to do. That's why I have been fortunate enough to stay on the road that I have stayed on, because I have friends who have the same goals or similar goals. We try to reach out to other youth, other people who may not be on that same road and tell them, look, there is another way. There's a better way to do things.

But I think abstinence can be realistic as long as we give full information. This country is somewhat sexually repressed. We are a little scared. We make things taboo that shouldn't be taboo. Procreation is natural. But we have to say that there's a time for it, there's a certain level of maturity you should have for it. But, if you feel the need to be sexually active at a young age, these are precautions you can take.

Senator SPECTER. I would like to ask your opinions on the question of motivation as it relates to welfare payments. And you have heard the earlier testimony about the subject as to cutting off welfare payments for the second or third child, or some are even saying the welfare payments ought to be cut off for any child. The issue is whether there is an incentive for a person to become pregnant because of the availability of the welfare check or, stated in reverse, that if there were no welfare checks, would that discourage teenagers from becoming pregnant.

Let me start with you on that, Mr. Braxton. What do you think?

Mr. BRAXTON. I see welfare as a way of maybe assisting pregnant teens to get on their feet. I do not think that once you get welfare payments you should lay back on it; just because it's coming in, you shouldn't have to do anything.

It's to me—like Project Independence, for one. They have programs for people who are on public assistance to have schooling so you can be able to get a job, get off welfare, and be dependent on yourself, and be able to take care of your child, and be more well aware of yourself and what you are going to do in life.

But welfare I think for the second and third child—after one you should know, if you ended up on welfare, that it's time to take time out and think before you have another one. Because if you're not getting help—if you're getting help from the outside and you're coming back with two and three more kids, you're expecting more help. That's the way I see it.

Senator SPECTER. Take time out to think before you have another one?

Mr. BRAXTON. Well, I would say, to be more specific, get yourself together.

Senator SPECTER. How about, in your words, taking time out to think before you have the first one?

Mr. BRAXTON. Well, that's true, too. But the only reason why I say the next one, if you already had one, it's time to just take a time out and think. We should do that before, anyway.

Senator SPECTER. Ms. Mary Morris, you have said that you did not want to be another person on welfare and that you do not rely on welfare, so your view should be especially significant here.

Ms. MARY MORRIS. When my daughter was first born, I did receive a check from welfare. And, you know, I thought it was all good and well. You know, these people are giving me money and I'm not doing anything for it.

And then times started getting harder and she needed more things, like bus fare to go back and forth to the clinic all the time, you know, just her needs that she needed by herself. And I was like, this money—you know, the money wasn't going anywhere, because I had to help. My mother used some of the money to help pay bills and things like that.

I mean, I was grateful that they helped me, but the little bit of money that they give you, you know, it doesn't go anywhere.

So I decided—I told my mother, I said, "Mom, call them and tell them that I don't want it anymore. I'm going to get a job." And I looked for a job for about 1 week, and I found one. And I've been working now for like 1½ months.

Senator SPECTER. What kind of a job do you have?

Ms. MARY MORRIS. I'm a cashier at a grocery store.

Senator SPECTER. How about when you go back to school?

Ms. MARY MORRIS. I'm still in school.

Senator SPECTER. Oh. At the same time?

Ms. MARY MORRIS. Yes.

Senator SPECTER. Well, good for you.

Ms. MARY MORRIS. I have a part-time job after school and on the weekends sometimes. I work maybe 30 to 35 hours a week making $4.35 an hour. So it's really hard to go to school.

This is my day schedule. I get up in the morning, bring the baby to school with me, put her in the day care, take my classes. After school, I just go in the door long enough to give the baby to my mother, tell her if she needs medicine or whatever, and then I go to work. By the time I come home from work, the baby is usually asleep, so I just take a shower.

And the days that I'm off, I don't plan anything for the days that I'm off, just to spend time with my child, because as well as me working, my child still needs me, you know. She needs to see other people like my mother, my other family members, but she needs to see me, too. So I just spend most of my time with her when I'm not working.

Senator SPECTER. Ms. Markita Morris, what is your view as to whether people would be disinclined to have the first child or subsequent children if there were no welfare payments?

Ms. MARKITA MORRIS. That subject somewhat scares me because I am reading "Brave New World" by Aldous Huxley right now. And anyone who is familiar with that book, or even "1984" by George Orwell, big brother is watching. I don't like the idea of the government trying to enforce contraception, in a sense. Yes; some people do take advantage of the system, but I'm not sure how effective cutting off subsidies for welfare would be as a deterrent.

As my mentor, Mr. Lee, has said once before, most poor people do not like being poor. Most poor people don't say, I'm happy being here, I'm happy being at this level. Some people take advantage of the welfare system. But I'm not sure how effective cutting it off after one child or two children would be. It may be more of a detriment to the child than that adult that you are trying to target.

So I think we should look at other options first before we start penalizing children for the acts of their parents.

Senator SPECTER. Well, now that I know you are reading Huxley and Orwell, we may submit a whole new list of questions to you, Ms. Markita Morris. [Laughter.]

I would say you are pretty much ahead of the educational curve.

Well, we thank you very much for coming in. Your insights are very valuable to the subcommittee because you are there, you are very young, and you see it differently. And we thank you for sharing your experiences and your thoughts with us.

That concludes our hearing.

CONCLUSION OF HEARINGS

The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 11:45 a.m., Wednesday, June 8, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

Material Submitted Subsequent to Conclusion of Hearings

[CLERK'S NOTE.—Additional statements were received by the subcommittee subsequent to the conclusion of the hearings. The statements will be inserted in the record at this point.]

STATEMENT OF LeANNA L. BENN, NATIONAL DIRECTOR, TEEN-AID, INC

Re: Adolescent Family Life Act - Title XX

Thank you for asking me about Title XX; it is always a pleasure to comment on this important piece of legislation. I was a technical advisor, read grants for two years, and then received funding as project director for 5 years.

Legislation designed to instill responsibility and family stability is scarce. This piece may have had its controversy but in my experience the families who have been a part are more than enthusiastic. Here is one grandparent's response who lives just north of Spokane to the Teen-Aid program, " We read the (homework) pages together. It was good because it explained everything in a decent, clear method. I answered his questions. Well written. It was moral and taught them to respect their person and their body. Teen-Aid teaches kids to be decent people. He wasn't embarrassed to discuss it with me or his mother."
One student said that Teen-Aid talked about things that his dad who was no longer in the home wouldn't. The program made him feel like he had a dad who would talk to him about these things.

Title XX is a concept that should be improved upon not discarded.The best part of AFLA was the evaluation component requirement. The unique part- and unfortunately still the unique feature of AFLA is that it is the only source of adoption and abstinence instruction/evaluation funding. The part which needs improvement is the continuation aspect. In Title XX, those programs, which showed promise were not funded again. Demonstration is invaluable and should not be abandoned but equally important is that success should be replicated. Many of the previously funded AFLA projects have shrunk or even folded because of lack of funding.

Times change - keep the best and don't keep making mistakes of the past.

All departments with programs intended to address teen pregnancy should report to Congress. Title X and XX should be required to have an outcome based evaluations on individual projects Then those projects that show promise and over time (five years) work they should receive ongoing funding with periodic outcome evaluations.

The difference between outcome and process evaluations is that the department would quantify results using scientific experimental and control groups.

AFLA was intended to address teen sexuality and the resulting societal problems from a sociological, systemic approach. A medical solution with contraception for teens does not work, has not worked and outside of a police state will not work with the immature relationships of teens. Teen-Aid found that medical information did not play a statistically significant part in a teens decision to remain safe and healthy. The internal drive for for friendship, acceptance and a sense of future motivated teens to postpone risk taking.

The teens using were 30% less sexually activity after one year than those who were not in our AFL project Yet with this success, Teen-Aid is not longer funded - at federal or state or local levels.

The intent was to research out new social solutions rather than costly medical technology. It was intended to make all the choice be more equal for an unintended teen pregnancy. After the court settlement on of the options-abortion can't even be mentioned and certainly not intellectually weighed as an option. Contraception - expensive medical solutions are no more the focus than internal control for pre and teen children. We need implementation in line with legislation, not a teeny bopper version of Title X family planning.

1) There is a real need to keep researching effectiveness of social solutions and their many positive spill over possibilities. Family communication and personal skills are more effective than prescriptions. AFLA did that effectively.

2) Current programs are not reducing pregnancies. STD's/HIV have their consequences and should be reevaluated prior to continued funding. Effective programs should be funded despite the politics or social opinion.

3) Office of Adolescent Health - Oversight of social solution programs should be under social services to the medical model doesn't get forced on grantee's. If nothing else was learned from Title XX research, it was that adequate funding for programs, as well as evaluation, is vital. My concern with the newly proposed Adolescent Health Office, is that they will be 1) duplicating Title X family planning services without family involvement or scientific evaluation, 2) adding additional social problems-gangs, violence, and drug use to the medical oriented department negates logical social solutions, 3) the broad scope of problems to be addressed is mind boggling when compared to the specificity in the AFLA project.

Enclosed you will find some of our results.

Thank you for defending a concept that must be kept going.

Five-Year Summary

Over five academic years (1987-1992), Teen-Aid® has been involved in an Office of Adolescent Pregnancy Programs through Health and Human Services funded research project that was geared toward the evaluation of the effectiveness of its sex education intervention program *Me, My World, My Future* and *Sexuality, Commitment and Family*. This program was designed to bring about awareness of sexuality information, to teach social skills, and to inspire in teens attitudes and values which would assist them in avoiding early sexual intercourse.

The Teen-Aid® sex education program was also designed to encourage non-virgin students (those who indicated having sexual intercourse at least once) to stop having sexual intercourse by explaining to them the short and long-term benefits of abstaining.

The basic underlying assumption of the Teen-Aid® sex education program was that sexual intercourse among teens was neither inevitable nor irreversible. The overall message of the curriculum was that sexual abstinence among adolescents is both normal and desirable.

This research endeavor began with a theoretical model which was employed to guide the research project throughout the five-year-period in identifying the key risk factors which seemed to be associated with intentions to have sexual intercourse. The theoretical model was designed to help enhance our understanding of the problem behavior targeted by the program. As this model has been developed, tested, and replicated over the last five years, it served as a practical tool against which the existing Teen-Aid® program components could be evaluated for and modified to improve their effectiveness in reducing sexual activity among teens.

High school students with low to medium values (intentions to abstain) had a 30% reduction in transition from virgin to non-virgin status over a year's time as compared to the control group. Transition rates for high school students were more apparent in the expected direction than for junior high students. The junior high curriculum addressed abstinence for one hour while the senior high spent 6 hours on resistance skill and sexual advantages/consequences. In response to this research the junior high program update expanded the one lesson to five lessons.

The basic underlying assumption of the Teen-Aid® sex education program was that sexual intercourse among teens was neither inevitable nor irreversible. The overall message of the curriculum was that sexual abstinence among adolescents is both normal and desirable.

In this summary, the following three types of research activities are highlighted: A guiding theoretical model, effectiveness of the Teen-Aid® program, and the teacher factor.

The major dependent variable investigated in this model was "INTENTIONS REGARDING SEXUAL BEHAVIOR." This variable as well as most of the constructs of the study were measured using scales developed from

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factor scores based on a pool of items included in the self-administered questionnaire. These constructs included Affirmation of Abstinence, Rejection of Permissive Sex, Peer Support, Peer Pressure, and Future Orientation. This model was slightly modified during the five-year period and was replicated successfully each year.

Research Design The general approach for the evaluation of the Teen-Aid® program was a pre-post, longitudinal follow-up, and control group comparison design.

Overall, the research findings obtained from the five-year project clearly indicated that the Teen-Aid® sex education program has consistently met many of its stated objectives of reducing the intentions to engage in sexual activity and hopefully, thereby, reducing the prevalence of associated consequences such as teen pregnancy rate, sexually transmitted disease rate, and dropout rate.

In sum, the five-year research project has demonstrated that the Teen-Aid® program has produced results which indicated that abstinence among teenagers is attainable.

While each of the five years research data indicated that the Teen-Aid® sex education prevention program made positive and statistically significant differences in attitudes, values, and intentions to have sexual intercourse among junior high school students, the "teacher factor" in administering a successful program emerged as a striking discovery. More specifically, this aspect of the sex education program had to do with the teacher's commitment (or lack of it) to teaching and communicating the program's philosophy and level of implementing objectives as presented in the curricula.

As currently designed, the Teen-Aid® curricula implementation does not require screening of teachers, special accreditation, or teacher accountability. While teachers do receive training in specifics of abstinence philosophy and Teen-Aid® curriculum content in an in-service training prior to their first year of teaching it, they are under no constraints once they enter their classroom. This of course could lead to a variety of styles, philosophies, and presentation strategies. It appears that this important factor needs more attention such as administrative support or frequent in-service training in the program and ultimately continued further analysis of the on-site data in order to understand more fully what is occurring.

The first probe into the teacher factor was initiated during the analysis of the third-year data. The "teacher factor" was suspected as an important rival hypothesis when inter-school comparisons were made in examining the data. These comparisons indicated that there was a varying degree of program success and impact by school on the following six composite measures of sex education program outcomes targeted by Teen-Aid®: Affirmation of Abstinence, Rejection of Permissive Sex, Sexual Intentions, Peer Support, Peer Pressure, and Future Orientation. In other words, the same sex education program impacted the target population differently in different schools but not necessarily in different student body compositions.

Therefore, a major objective of the fourth and fifth year data focussed on further investigation of this phenomenon. This objective was accomplished by collecting data from teachers in addition to the student data and by

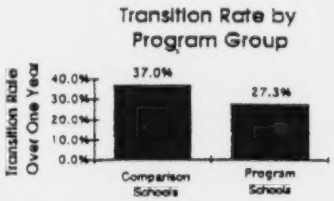
linking student with teacher data for analysis purposes. The results uncovered what seemed to be an extremely important component for the success of any sex education intervention program.

The fourth and fifth year data indicated that indeed there were statistically significant differences in program outcomes across the different teachers who introduced the Teen-Aid® curriculum. Program results were greater and were in the expected direction among students taught by teachers characterized by a greater level of program implementation and by a greater level of commitment to the underlying philosophy of the program than they were among students taught by teachers with lower levels of commitment to program implementation and its philosophy.

These results held up across all composite measures of Affirmation of Abstinence, Rejection of Permissive Sex, Sexual Intentions, Peer Support, Peer Pressure, and Future Orientation for both male and female respondents. The effect of the teacher factor on having a successful sex education program was observed more strikingly in the fourth than in the fifth year data.

To Teen-Aid®, the implications of the fourth and fifth year results seemed to be very clear. To produce the desired effects, a sex education program, especially one that is based on abstinent sexual lifestyles, must not rely *solely* on a well-written, thoughtful or even research curriculum. Rather, it must 1) follow a multifaceted approach such as initial selection of teachers who are willing to fully implement the program and committed to adhering to the basic philosophical premises and 2) if at all possible an on-going, quantitative evaluation of student value and behavior outcomes. Either a copy of this evaluation survey instrument or a simplified version could be utilized to give staff feedback in maintaining program consistency over time.

In sum, the five-year research project has demonstrated that the Teen-Aid® program has produced results which indicate that abstinence among teenagers is attainable. Teaching abstinence does indeed reduce the probability of teens to have sex, and hopefully reduces other outcomes as well: contraction of STDs and HIV, the frequency of pregnancy, the need of raising a child alone, and abortion. Finally, the role of the teacher is found to be critical in having an effective sexual postponement curriculum.



Yes, Teen-Aid® can help teens say No

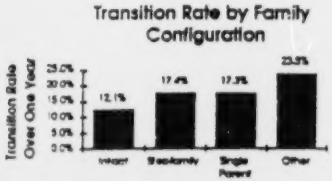
Understanding the Graphs and Forming Policy

The following graphs show factors which play a part in a teen's decision to initiate sexual activity. In sorting out the teen pregnancy problem, the need to find related or even unrelated activities which would aid in the postponement of sexual activity and thereby delay pregnancy became apparent. Some of these seemingly related activities may be more easily influenced than making a frontal assault on the complex issues of teen sexuality and teen pregnancy. Some of these behaviors seem to influence the change or ***transition rate*** from being a virgin to becoming a non virgin in the year following the first measure of values and attitudes. An anonymous pre test was given to students before the Teen-Aid® program, then the program was given followed by a post test. In the case of the control or comparison schools, the pre test was given, a three week delay with

no program occurred, then a post test was given. In both program and comparison schools the students were matched by their sex and date of birth. A year later, a follow-up test was administered to the same students, their answers were matched with the tests from the previous year in order to measure a change in behavior. Important to note is that the attitudes and values expressed a year earlier were accurate predictors of whether the teen would initiate sexual activity one year later.

Who can influence or control the following situations?

The home may be best suited or most responsible for some behaviors and therefore most effectively express the expectation for those behaviors. In some cases the school programs like Teen-Aid® can positively impact situations and expectations which directly impact important factors in the onset of sexual activity.

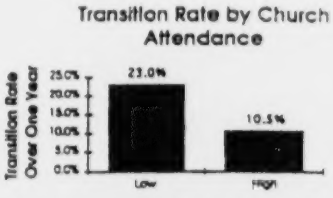


Family structure impacts the level and onset of sexual activity for the children within those configurations. Families may not be able to return to the intact situations so they must function in a step or single parent configuration. Families in these configurations may need additional support to help their children remain abstinent. Ideally communities then should have a partnership role in being the support for families who have children at greater risk.

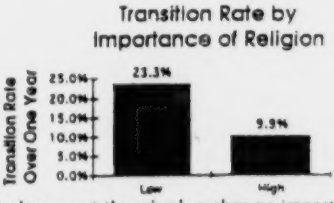
As young people begin setting expectations for their own future family structures, understanding the family structure implications may positively influence their commitment decisions.

The "other" category includes living with foster/guardian, an extended family member or as an emancipated minor.

Two parents at home make it harder for teens to have sex



Students were asked if they attended religious/ church services and how often. The answer to this question was then linked to the answer of whether they were sexually active one year later. These results were from public schools. Religious attendance and attitudes were measured before the Teen-Aid® program presentation and again after the school program. The Teen-Aid® program made no impact on attitudes about religion which may be the best way to express that it is not a religious program. Religiousness comes from outside the public school but has an obvious impact on the initiation of sexual activity.

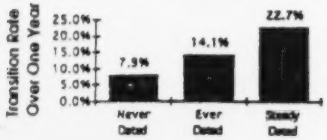


The home, not the school, makes an impact on the level of importance of religion and level of church attendance. Levels of importance and attendance seem to make similar

and significant impact on teens' sexual behavior. The value of participation in religion has a positive and significant impact which policy makers should note as well as avoiding any actions which might undermine this value.

Statistically, Teen-Aid® doesn't teach religion, but more importantly it doesn't undermine religion which helps delay sex

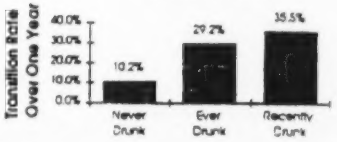
Transition Rate by Dating Patterns



Dating patterns are most likely influenced by family standards but schools can reinforce parental roles by the use of certain curricula and by reducing the pressure for peers to couple off. The junior and senior high students demonstrated that teens can have sex without dating but steady or more long term relationships increase the likelihood of sexual activity. The cause was not determined as to whether it was because of increasing opportunity or perceived levels of emotional and physical commitment.

Going steady may mean going "all the way"

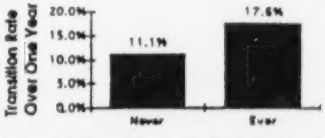
Transition Rate by Drunkenness



The home plays a major part in the expectations and access to alcohol which relates to drunkenness. However, school programs and the activities of immediate peers also impact this factor. Alcohol consumption plays a tremendously important role in whether or not a teen will begin having sex. Not in this research but in other studies, the impact of alcohol on the consistent use of contraception and increased number of partners makes alcohol important to address at both home and school.

I just can't be pregnant. We were drunk so the sperm must have been drunk and couldn't have found its way. Sperm are too smart to drink.

Transition Rate by Level of Truancy

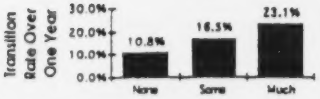


Truancy plays a role and is included in the cluster of behaviors which put teens at a higher risk of initiating sexual activity and subsequently experiencing pregnancies and other consequences. Skipping school may speak to the inner feelings of competency as well as a willingness to break rules, inability to see the long term consequences of personal behavior, decreased future goals, or merely

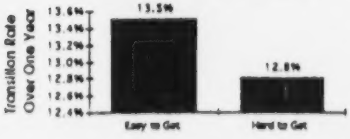
more time available to engage in behaviors which lead to sexual activity. More focused research is needed to give specific causes, but a policy of home and school cooperation in reducing truancy may be a practical procedure in reducing sexual activity rates.

I cut history classes now my baby is cutting teeth.

Transition Rate by Birth Control Information Received



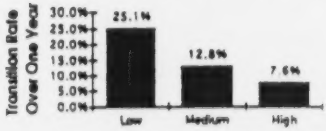
Transition Rate by Ease of Access to Birth Control



Would Mr. Smith have hyped birth control if he didn't think we could handle having sex?

Perception and ease of access to birth control for unmarried teens is both a home or community issue and a school issue. The slogan, "Do no harm" may apply to policy about increasing teens' perception of access. However, difficulty of obtaining services made less impact than actual information or student perception about adult expectations for the immediate need and use of birth control. In Title XX research done relating to the effectiveness of abstinence education material, large amounts of information about delivery of the birth control message are not available. The information that was available came from classrooms where the teachers added additional materials beyond the scope of the school district program or at least beyond the Teen-Aid® classroom program. Content, delivery or teacher instruction were not measurable or controllable in this project.

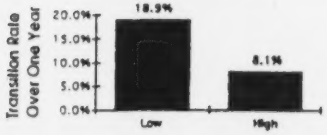
Transition Rate by School Grades



No, thanks, I prefer college to a colicky baby.

Students with higher grades are less likely to initiate sexual activity. Grades may be a composite measure of a students future intentions toward success or related to perceived personal worth. Focusing on the grade factor gives another indicator and possible solution for reducing levels of sexual involvement. Programs addressing scholastic achievement can be begun in elementary grades and can be another bridge in building parent school relationships. Understanding the connection between scholastics and teen pregnancy gives another angle to assist teens and their families.

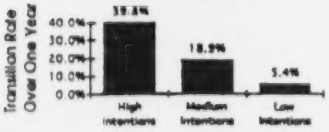
Transition Rate by Future Orientation



There is life after age 15 — especially without AIDS

Students who perceive that their personal actions today have consequences which impact their future are less likely to initiate sexual activity. This is one measure on the values scale in which the girls lagged behind boys at pre test. The Teen-Aid® classroom teachers were able to reinforce or teach a sense of the future during the program. At post test, girls' sense of future were more impacted by classroom discussions than were boys which brought them nearly up to the boys' level of future intention for success.

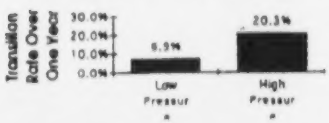
Transition Rate by Intentions to Have Sexual Activity



What you intend to do gets done. What you don't plan on doing waits?

Measuring levels of sexual activity or sexually transmitted diseases are not always accurate on a self administered test. Behaviors are less likely to be revealed than attitudes and values, and tests with questions about behaviors are harder to get permission to administer. The benefit of this federally funded research was to gain permission from districts to gather this often difficult information. The correlation between intentions and future behavior can be used in sites where attitudes, but not behavior can be measured to monitor program results.

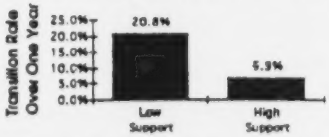
Transition Rate by Peer Pressure for Sexual Activity



Uh, am I must be the last virgin in the state?

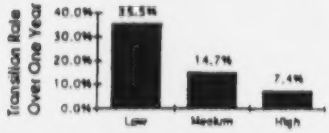
Peer pressure to have sex and peer pressure to remain abstinent appear to be equally as significant. Classroom presentations with committed teachers can increase peer support for abstinence and a rejection of permissive behaviors which may result in sexual involvement. Parents may be able to play a role in the friendships of their children.

Transition Rate by Peer Support for Abstinence



Good friends help you stay away from drugs and sex.

Transition Rate by Abstinent Values



Values drive behavior more than knowledge

One of the most revealing results was that increased information by itself did not change behavior in a positive direction. It appears in this research, as well as many other studies being done currently, that values motivate the individual to change behavior. The sex education policy implications and struggles based on values education and the specific behavior changes desired may consume communities for at least the rest of this decade.

LETTER FROM BRIAN L. WILCOX, PH.D., AND SUSAN P. LIMBER, PH.D., ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

The Honorable Tom Harkin
Chairman
Subcommittee on Labor-Health and Human Services and Education
186 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

June 24, 1994

Dear Senator Harkin:

We are writing on behalf of the American Psychological Association to thank you and Senator Specter for holding recent hearings on the topic of "Teen Pregnancy." Teenage pregnancy is indeed a critical issue facing this country, as approximately one million American teenagers become pregnant each year. The hearings produced some very thoughtful testimony about promising ways of both preventing pregnancy among teens and supporting teen parents and their children.

After reviewing the testimony presented at the hearing, we would like to comment on the testimony presented by Lakita Garth and Coleen Mast. These witnesses presented information regarding the effectiveness of two sex education programs that have been funded under Title XX of the Adolescent Family Life Act and administered through the Office of Adolescent Pregnancy Programs. These two programs, like all sex education programs funded under Title XX, focus exclusively on abstinence as a means of delaying sexual activity and reducing pregnancy and sexually transmitted diseases. We examined evaluations of a number of Title XX programs, including those referred to in testimony, we conclude that statements made by Ms. Garth and Ms. Mast were misleading and in some cases completely erroneous. We appreciate this opportunity to comment on each.

In her testimony before the subcommittee, Ms. Garth noted that a number of Title XX sex education programs have had "impressive outcomes," and she cited statistics demonstrating the effectiveness of one particular Title XX program, the American Home Economics Association's "Project Taking Charge." Ms. Garth stated that students who participated in Project Taking Charge were four times less likely than other students to initiate sexual intercourse. After reviewing evaluations of the program and discussing the results with representatives of the American Home Economics Association and evaluators of the program, we conclude that this claim is completely erroneous. Published evaluations of Project Taking Charge report increases in students' knowledge about anatomy sexually transmitted diseases and note small decreases in students' self-reports of sexual activity six months following the completion of the program. These small decreases in self-reported sexual activity hardly constitute the "impressive outcomes" noted by Ms. Garth. Moreover, given the methodological limitations of the study, it is premature to conclude that the program alters adolescents' sexual behavior to any extent. The evaluation examined the self-report behaviors of only a small number of students who had participated in the program. Whether these marginal changes in self-reported behavior reflect actual sexual behavior or whether they instead reflect students' desires to give socially desirable responses is not known.

A second Title XX program, Sex Respect, was described in detail in the testimony of Coleen Mast, author of the Sex Respect curriculum. In her written statement, Ms.

Mast asserted that "Sex Respect is the most effective abstinence education program available to public schools" and that the curriculum has been proven to substantially reduce the incidence of teen sexual activity. Unfortunately, our examination of the Sex Respect program does not support this glowing assessment. In fact, after reviewing two studies that evaluate the Sex Respect program, we conclude that there is no scientifically sound evidence to indicate that the program has had any significant effect on students' sexual behaviors.

Evaluations of Sex Respect indicate that students are more likely to espouse beliefs consistent with the Sex Respect program after having recently completed the curriculum. For example, at the conclusion of the Sex Respect program, students were more likely to agree with statements such as "Sexual urges are controllable" and "It is important for me not to have sex before marriage." However, whether these findings reflect actual changes in students' attitudes or whether they reflect students' desires to provide socially desirable responses is not known. Although it is quite common for researchers to independently measure the likelihood of participants to answer questions in a socially desirable manner, the evaluators of the Sex Respect program did not attempt to do so. Nor did the evaluators succeed in measuring the extent to which students' attitudes towards abstinence persisted after the completion of the Sex Respect program. The one study that attempted to do so was so methodologically flawed that it's findings must be considered inconclusive.

Even if Sex Respect has succeeded in changing students' attitudes towards abstinence, there is no indication that these attitudes have translated to changes in students' sexual behaviors. Social scientists have long observed that the relationship between individuals' attitudes and behaviors is often quite weak. Thus, in order to determine the effectiveness of any sex education program, it is critical that evaluators measure not only students' attitudes but also rates of student's sexual behaviors. Two evaluations of the Sex Respect program attempted to measure such behaviors. However, flaws in the design of the studies and inadequate reporting of data make it impossible to determine whether students are any less likely to engage in sexual activity as a result of having participated in the Sex Respect program. Based upon the existing evaluations of the Sex Respect program, it is currently indefensible to conclude that Sex Respect successfully influences the sexual behaviors or even the enduring sexual attitudes of students.

Evaluations of Sex Respect and Project Taking Charge are not unique in their failure to prove the effectiveness of abstinence-only sex education. We have reviewed evaluations of a number of additional Title XX programs, including Teen-Aid, and have failed to find any methodologically sound studies that demonstrate that abstinence-only sex education curricula reducing rates of teen sexual activity or pregnancy. This is not to say that abstinence education is unimportant. To the contrary, many adolescents want to abstain from sexual activity and may benefit from sex education that assists them in making this decision. However, those sex education programs that have been found to be effective in delaying the onset of sexual activity and in reducing rates of unprotected intercourse among teens are comprehensive in nature, discussing *both* abstinence and contraception. We encourage policymakers to support these promising comprehensive approaches to sex education.

We have attached a copy of a paper that we recently presented at a meeting of the Society for Research on Adolescence, which discusses these issues in more detail. Please feel free to contact us if the American Psychological Association can be of

any assistance. Thank you again for your leadership in addressing issues of teenage pregnancy.

Sincerely,

Brian L. Wilcox, Ph.D.
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PAPER SUBMITTED BY CAROL L. BARTELS, SUSAN P. LIMBER, HEATHER O'BEIRNE, AND BRIAN L. WILCOX ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Federally Funded Abstinence-Only Sex Education Programs:

A Meta-Evaluation

In recent years, levels of sexual activity among teenagers have increased considerably. Half of all unmarried adolescent girls and 60% of unmarried adolescent boys aged 15-19 have had intercourse (Alan Guttmacher Institute, 1993). Teenage pregnancy rates and birth rates also have increased dramatically in recent years. Currently, the United States has the highest adolescent pregnancy rate in the industrialized western world, totaling more than one million teenage pregnancies per year (Alan Guttmacher Institute, 1993). The teen birth rate has risen nearly 25% between 1986 and 1991, from 50 to 62 births per 1,000 adolescent females (ages 15-19). In 1991, over half a million babies were born to adolescent girls in the U.S. (Child Trends, 1994). A recent study suggests that in 1988 the federal and state governments spent approximately $22 billion supporting adolescent parents and their children (Armstrong & Waszak, 1990).

Federal Policy

Despite the human and economic costs associated with adolescent pregnancy and childbirth, federal policymakers expressed little interest in the problem until the mid-1970's. The timing of Congressional interest may be a result of several factors. First, a highly publicized report by the Alan Guttmacher Institute (1976) detailed an "epidemic" of adolescent pregnancy (c.f. Vinovskis, 1988) and was extensively cited by both media and policymakers. Second, federal costs associated with adolescent pregnancy grew through the 1970's, around the same time that public support for welfare policies and their recipients

began to wane (Garfinkle & McLanahan, 1986). Third, with the legalization of abortion in 1973, adolescent abortion rates increased substantially, attracting the attention of anti-abortion legislators. And finally, adolescent mothers increasingly chose to keep their children and were less likely to marry prior to or after the child's birth. This demographic trend has continued and has had the effect of making adolescent mothers more visible to the public. The combined set of fa tors seemed to spur legislative action.

The Adolescent Health Services and Pregnancy Prevention and Care Act of 1978 (Title VI of the Health Services and Centers Amendments Act) represented the first federal legislation explicitly and exclusively directed at the problem of adolescent pregnancy. The original version of the legislation focused heavily on prevention and sex education, but advocates for services for pregnant and parenting adolescents succeeded in amending the bill to focus much more heavily on research and services for these adolescents. The final act deemphasized prevention and strengthened care provisions. Throughout its short history, the Title VI program was plagued by limited funding, and the program was eventually dismantled by the Reagan administration in 1981.

Concerned that federal family planning services condoned adolescent sexual activity by making contraceptives available to teens, Senate conservatives led an effort which resulted in the passage of the Adolescent Family Life Act (AFLA) in 1981. Today, AFLA remains the primary federal program whose purpose is to prevent adolescent pregnancy. Under two Republican administrations such programs have focused almost exclusively on reducing adolescent sexual activity and promoting abstinence from pre arital sexual relations, prompting critics to dub the legislation the Chastity Act." In the thirteen years since the enactment of AFLA, several million dollars have been spent to support abstinence-only sex education programs in schools across the country, but little information exists in the professional literature concerning the effectiveness of these programs.

Characteristics of AFLA-Supported Abstinence-Only Sex Education Programs

Typically, these school curricula are presented to Junior and Senior High school students in 3-4 week health courses. Through workbook exercises and group activities in classrooms, students are taught that sexual abstinence is the only effective and healthy means

of preventing teen pregnancy and sexually transmitted diseases. If contraceptive devices or safe-sex practices are mentioned in the materials, they are portrayed as presenting serious health hazards to adolescents and as being ineffective in preventing pregnancy and disease.

While AFLA has provided funds for such programs for over a decade, we currently know very little about their effectiveness. Although AFLA programs are required to include evaluation components to determine their effectiveness, relatively few of these evaluations have been published or even made available to the public. Those that have been made public typically conclude that abstinence-only curricula are successful in promoting attitudes of sexual abstinence (but see Christopher & Roosa, 1990; Roosa & Christopher, 1990). Some assert that the programs have produced measurable changes in adolescents' sexual behavior.

Methods

In an attempt to evaluate the validity of such claims, we conducted a meta-evaluation of five program evaluations that were submitted to the Department of Health and Human Services. The evaluations examined the effectiveness of the following abstinence-only sex education programs: "Sex Respect: The Option of True Sexual Freedom" (evaluation by Weed, Olsen and Hooper, 1987); "Me, My World, My Future" (Teen AID) (evaluation by Weed, Olsen, and Tanas, 1988; 1989); "Family Accountability: Communicating Teen Sexuality" (FACTS) (evaluated by Weed and Olsen, 1990); and "Living Smart" (evaluated by Young, Core-Gebhart, and Marx, 1992). We examined four basic components of these program evaluations: (a) basic hypotheses and assumptions of the researchers, (b) study design and methodology, (c) data analysis, and (d) researchers' interpretations of the results and conclusions about the program's effectiveness.

Results

Our meta-evaluation revealed numerous common flaws among the five program evaluations that we examined (see Table for a detailed summary).

Hypotheses and Assumptions

Researchers consistently made unsupported claims about correlates of adolescent sexual activity. For example, Weed and colleagues (1989) noted that sexual activity in adolescence interferes with educational achievement and the quality of future relationships,

but they cite no evidence to support their statement. Most investigators also made the unsupported assumption that changes in adolescents' attitudes and/or knowledge about sexual activity are directly linked to changes in their sexual behavior.

Design and Methodology

Researchers failed to provide critical information about how participants were selected to participate in the study. Moreover, essential information about characteristics of the sample populations was omitted in many evaluation reports. For example, only two of the five evaluations provided adequate descriptions of the ages, gender, ethnic background, and family composition of participants. Other important demographic information, such as the grades of participants, the type (e.g., private vs. public) and location (e.g., urban vs. rural) of participating schools was omitted from all evaluations.

Researchers also employed inadequate dependent measures in their evaluations. Evaluators typically used students' attitudes about sex as the sole dependent variables. In four of the five evaluations, researchers did not attempt to measure sexual behaviors of adolescents. Instead, they relied upon attitudinal measures as indications of behavioral change. None of the evaluations adequately described the psychometric properties of either attitudinal or behavioral measures.

Not only did evaluators use inadequate measures of change, but they typically used study designs that were inadequate to assess the effects of a sex education program on participants. Researchers typically employed a single-group, pretest-post quasi-experimental design. Only one evaluation used a no-treatment control group, and none compared responses of adolescents who had experienced the abstinence-oriented curricula with responses of adolescents who had experienced a more comprehensive sex education curricula. Without such control and comparison groups, it is impossible to attribute changes in students' attitudes solely to the abstinence program. Moreover, researchers failed to collected long-term, follow-up data, thus making it impossible to determine the extent to which any changes in students' attitudes and behaviors endured over time.

Data Analysis

Researchers universally failed to adequately report the results of their evaluations.

They commonly failed to provide such critical information as significance levels, sample sizes, means, and standard deviations. Omission of critical statistical information made it difficult for us to determine whether several researchers accurately employed statistical techniques. However, from available information, we concluded that most researchers used very simplistic, and frequently inappropriate analyses (i.e., multiple t-tests) that may have may have inappropriately revealed significant changes in students' attitudes and behaviors where none actually existed.

Interpretations and Conclusions

Not only did most researchers obtain suspect research findings, but they also universally failed to interpret these results with adequate caution. They frequently made unsupported claims about the relationship between sexual attitudes and sexual behavior, concluding that observed changes in students' attitudes from pre- to post-test would result in long-lasting changes in rates of students' sexual activity.

Discussion

Under the Adolescent Family Life Act, the federal government has spent millions of dollars to support abstinence-only sex education programs. Evaluators of these programs have concluded that curricula such as Sex Respect, Teen AID, FACTS, and Living Smart are effective in promoting attitudes of sexual abstinence and in decreasing sexual activity among teens. However, because of the universally poor quality of the program evaluations that we have reviewed, we conclude that such claims are completely unwarranted. To date, we are aware of no methodologically sound studies that demonstrate the effectiveness of curricula that teach abstinence as the only effective means of preventing teen pregnancy. Although credible evidence is lacking to show the effectiveness of abstinence-only sex education programs, methodologically sound studies have shown that more comprehensive sexual education approaches, which provide students with behavioral strategies for avoiding sexual intercourse, can be successful in delaying the onset of sexual activity and in reducing rates of unprotected intercourse among teens (see Kirby, 1994 for review).

The AFLA experience suggests to us that if the federal government is to be responsible in its efforts to reduce rates teenage pregnancy, it must be open to funding

comprehensive sex education programs and it must practice more diligent oversight of its federally-funded pregnancy prevention efforts. The Clinton administration has proposed abolishing the Adolescent Family Life Act in its fiscal year 1995 budget. Whatever replaces this program, Congress and the administration should assure that competent evaluation, built into interventions from the outset, are an integral part of the program.

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DESIGN

Sampling

Adequate description of total sample characteristics:	Sex Respect	Teen AID 1	Teen AID 2	Living Smart	FACTS
sample size	X	X	X	X	X
ages of participants?	X	--	X	--	--
gender of participants	X	--	X	--	--
grade of participants?	--	--	--	--	--
location (urban/rural, region of country?)	--	--	--	--	--
type of school (private, public)?	--	--	--	--	--
racial/ethnic background?	X	--	X	--	--
family composition?	X	--	X	--	--
religion/religiousness?	X	--	X	--	--
level of sexual activity?	--	--	X	--	--
Discussion of within group hetero/homogeneity?	--	--	--	--	--
Discussion of between group hetero/homogeneity?	--	--	--	--	X
No-treatment control group?	--	--	--	X	--
Comprehensive sex education group?	--	--	--	--	--
Random assignment of subjects to conditions?	NA	NA	NA	--	--
Discussion of/controls for selection bias?	--	--	--	--	--
Discussion of/controls for attrition	--	--	--	--	X

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	Sex Respect	Teen AID 1	Teen AID 2	Living Smart	FACTS
Procedure					
Voluntary participation of subjects?	?	?	--	X	?
Confidentiality of responses?	?	X	?	X	?
Measure of/control for social desirability?	--	--	--	--	--
Long term follow-up to determine effects of program over time?	--	--	--	--	--
Measurement					
Are IVs and DVs logically related?	X	X	X	X	X
Does evaluation measure changes in behavior?	--	--	--	X	--
Control for bias in outcome measures (e.g., leading questions/social desirability)?	--	--	--	--	--
Report reliability/validity of measures?	--	--	--	--	--
RESULTS					
Adequate reporting of results?	--	--	--	--	--
Attempts to assess power?	--	--	--	--	--
Attempts to assess effect size?	X	X	X	--	--
Accurate use of statistical techniques?	--	?[2]	?[2]	--	X

CONCLUSIONS

Interp. consistent w/data and study limitations?	--	--	--	--	--
If references to causality are made, are they warranted?	--	--	--	NA	--
Adequate discussion of strengths and limitations of study:					
general design	--	--	--	--	--
sampling	--	--	--	--	--
measures used	--	--	--	--	--
analyses	--	--	--	--	--

Legend

X = Yes
-- = No
? = Insufficient information to determine
NA = Not applicable

Footnotes

1
Demographic information was provided for a large initial sample of participants. However, analyses were conducted on a smaller group for which demographic information was not given.

2
Omission of important statistical information (e.g., sample sizes, probability levels) precludes judgment of the accuracy with which the statistical procedures themselves were used.

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ISBN 0-16-046176-6